Australian Government
Australian Institute of Health and Welfare

Health expenditure Australia 2021-22

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About

Regular reporting of national health expenditure is vital to understanding the health system and its relationship to the economy as a whole.

- Total health spending was $241.3 billion, equating to $9,365 per person.
- Health spending increased by 6.0% in real terms, which was higher than the decade average growth of 3.4% per year.
- Government health spending increased by 9.5% while non-government spending was estimated to decline by 2.4% in 2021–22.

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Findings from this report:

- Total health expenditure was $241.3 billion, equating to $9,365 per person or 10.5% of total economic activity
- The ratio of government health spending to government expenses increased by 1.8 percentage points compared to 2020–21
- In 2021–22, spending on hospitals was $96.0 billion, a real increase of 4.6% compared with the previous year
- In 2021–22, spending on primary health care was $84.1 billion, a real increase of 10.9% compared with 2020–21

Summary

In 2021–22, an estimated $241.3 billion was spent on health goods and services in Australia. This equated to an average of approximately $9,365 per person and comprised 10.5% of overall economic activity.

After adjusting for inflation, total health spending (recurrent and capital) was 6.0% more than in 2020–21. This was higher than the average yearly growth rate over the decade to 2021–22 (3.4%).

Growth in per person health expenditure in 2021–22 was 5.4% in real terms, similar to the growth in 2020–21 (6.6%), but well above the average growth rate over the decade up to 2021–22 of 2.0%. This can be attributed to the impact of the pandemic which resulted in increased health expenditure and decreased population growth.

Governments funded around 72.9% of health spending – $105.8 billion by the Australian Government and $70.2 billion by state and territory governments in 2021–22.

Unlike the previous year, when health spending by government and non-government sources increased, in 2021-22 government spending grew by 9.5% while non-government spending declined by 2.4% in real terms.

The ratio of government health spending to total government expenses across all portfolios increased by 1.8 percentage points (from 15.5% in 2020–21 to 17.2% in 2021–22). This indicates that growth in government health spending grew stronger than other areas of government expenses.

During 2021–22, the greatest increases in recurrent spending were for:

- primary health care, a $8.3 billion (10.9%) increase in real terms, which was associated with increased spending related to the pandemic, such as COVID-19 vaccines, and personal protective equipment.
- hospitals, a $4.2 billion (4.6%) increase in real terms. This growth in hospital spending was partially driven by an increase in hospitalisations involving a COVID-19 diagnosis.

Introduction

The AIHW has been reporting on health expenditure in Australia for more than 3 decades as part of preparing Australia's National Health Accounts (ANHA). This Health expenditure Australia report presents estimates of the amount spent on health goods and services in Australia for 2021–22, and the decade leading up to this. This report's estimates are based on data from the AIHW's Health Expenditure Database (HED), a collation of more than 50 data sources capturing health spending by governments, individuals, private health insurers and other private sources. The purpose is to use the best available data to provide the most comprehensive picture of (i) how much was spent on health, (ii) funded by who, and (iii) on what areas of health goods and services.

The ANHA aims to support a long-term, whole-of-system understanding of health spending nationally and over time. This system is unique in Australia, and it varies from other health system reporting in scope, degree of stability over time and classification systems used. Other systems tend to focus on specific funding programs, jurisdictions or time periods.

The long-term holistic approach within the ANHA requires methods to appropriately allocate spending figures from multiple and often overlapping data sources. These sources change over time to the relatively stable 'area' and 'source' categories used in the ANHA. In doing so, care is taken to avoid the risk of misallocation, unnecessary breaks in the time series, missed data and double counting.

The methods used in the ANHA are overseen by the Health Expenditure Advisory Committee (HEAC). The HEAC includes subject matter experts and representatives from the Australian Government and all state and territory governments, as well as some non-government organisations. The AIHW has worked with the HEAC over many years to develop approaches to maximise the completeness and accuracy of the estimates over time and minimise the risk of double counting. For example, when estimating total spending on hospital services in a year, the funds the Australian Government gives to states and territories are subtracted from the hospital spending reported by the states and territories to derive the amount that the states and territories spent from their own resources. Further information can be seen at Compilation of health expenditure estimates.

The holistic approach, unique classification system and methods developed for the ANHA mean the figures reported here often vary from other data sources, particularly where other reporting tends to focus on specific funding programs, institutions, funders or purposes. For example, program-specific reporting such as for the Medicare Benefits Scheme, government budget papers or health department annual reports vary from the figures here due to differing classifications, scopes and methods used to account for double counting. See Comparison and alignment of health expenditure estimates for detailed information.

As part of ongoing data quality improvement activities, the AIHW, through the HEAC, works with the Australian Bureau of Statistics (ABS), Department of Health and Aged Care, State and territory Health Departments, the National Health Funding Body (NHFB), the Organisation for Economic Co-operation and Development (OECD) and other data suppliers to ensure the estimates presented in the ANHA are as complete and accurate as possible and reflect changes in health system financing over time.

This report includes Department of Defence spending in more detail than in previous iterations as well as reference to potential adjustments to estimates surrounding spending on services provided in hospitals (particularly certain services funded through the Medicare Benefits Scheme (MBS)). These potential adjustments suggest that some spending on referred medical services could be captured in hospital spending (i.e. a re-allocation of spending between categories). At this point, data limitations prevent a full inclusion of these adjustments within the ANHA, however, an attempt to quantify the potential impacts has been included in this report and the AIHW continues to work with data providers to resolve the outstanding issues for future reporting.

A summary of some of the broad issues is provided below. See Australian National Health Account: Overview of data sources and methodology for more information on data sources and methodologies, as well as a comparison between this report and other health spending figures published elsewhere.

Examples of other health expenditure reporting

Examples of other health expenditure reporting include:

- The Australian Bureau of Statistics (ABS) uses the System of National Accounts to report Australia's National Accounts (ABS 2016). This economy-wide classification system is broader than just the health sector and uses different data sources, classifications and estimation methods to the ANHA to ensure consistency across the economy. For example, where spending through health insurance is considered part of the health system under the ANHA, it is considered part of the insurance sector in the System of National Accounts. Another reason for variation comes from the ABS use of the Government Finance Statistics (Australian GFS, or AGFS, referred to as "GFS" in this report) as a source for government spending, which varies from the source used by the AIHW, the latter having been tailored specifically for the ANHA. While the basis for both systems is the general ledger transactions that are recorded by the various government agencies, including Departments of Health, the two vary for a number of reasons, including:
  - The GFS approach is a 'purpose' classification, which means that the basis for classifying expenditures is the purpose for which the expenditure relates, rather than the nature of the product or service purchased. This means, for example, that remote housing constructed for the purpose of housing medical staff would be treated as health spending in the GFS but not in the ANHA.
  - The health classification in the GFS potentially includes activities that are outside of the scope of the ANHA (e.g. nursing and convalescent home services) and may exclude activities that are within the scope of the ANHA (e.g. private health insurance premium rebates).
- All governments within Australia produce financial reports, including annual reports, budget papers and specific program data. While these generally use the same source data as are provided to the AIHW (audited financial statements and 'general ledgers'), variations in scope can occur between what might, for example, be in a report covering spending across a health and human services portfolio and what is needed for the ANHA. Classifying the data to fit the ANHA classification system can require adjusting specific items to avoid duplication, or drawing on other data sources, such as hospital activity data, to 'fit' the spending into ANHA categories. For example, staff engaged by a specific health service might technically be considered departmental staff in some states and territories. In these cases, spending can essentially be captured twice in the annual report, but this duplication is eliminated for reporting to the AIHW. The states and territories conduct this work each year as part of the Government Health Expenditure National Minimum Data Set (GHE NMDS) collation. The AIHW continually reviews this with the states and territories bilaterally and through the HEAC to maximise consistency over time and between jurisdictions. The results, however, inevitably vary to some degree from what is publicly reported. A high-level indicative overview outlining the variation between the ANHA figures for governments and the figures reported in the respective health authority annual reports for 2021–22 is presented in Table C2 to illustrate the observed variations.
- The Administrator of the National Health Funding Pool (NHFP), supported by the National Health Funding Body (NHFB) publishes data on funding and payments through the NHFP that was established under the National Health Reform Agreement (NHRA). These data form an important component of the spending outlined in this report, particularly with public hospital spending. However, not all public hospital spending outlined in this report is administered through the NHFP, so additional information sources are drawn on to capture the full scope of public hospital spending. Note that "public hospital spending or "spending on public hospitals" in this report are actually referring to public hospital services as an area of expenditure, not public hospitals as entities.
- Each year the AIHW provides a derivation of the ANHA to the Organisation for Economic Co-operation and Development and the World Health Organization in accordance with the classification used for international reporting, known as the System of Health Accounts. Despite being derived from the same source data, differing classification systems can result in variations in health spending for particular components of the health system. For example, the System of Health Accounts tends to report on comparisons of recurrent health spending excluding capital across OECD countries. Health and medical research is also excluded in the SHA while it is included in the ANHA.

2021–22 was the third year (and the second full year) of the COVID-19 pandemic in Australia. The pandemic not only affected health spending in direct (mainly through governments' programs such as the NPCR) and indirect ways (mainly through reduced activities due to pandemic-related lockdowns, restrictions, and temporary suspension of non-urgent elective surgery), but also affected the data collection and processing for health expenditure itself.

Introduction

The health spending presented in this report represent the best estimates based on the available data and methodology used. Results are based on the HED finalised as at 19 September 2023.

Prices

Constant prices are used to present spending estimates in this report, unless otherwise indicated. Constant price estimates in this report are based on 2021–22 prices. Current prices represent the dollar amount spent in the year referred to.

Presentation of the dollar value of spending estimates

Current prices

Spending in current prices refers to spending not adjusted for movements in prices (inflation) from 1 year to another and therefore represents the dollar amount spent in that year.

Comparisons over time using figures expressed in current prices can be misleading due to the effect of inflation and changing value of money. For example, $1 billion spent in 2011–12 bought more health goods and services than $1 billion spent in 2021–22.

Changes from year to year in the estimates of spending in current prices are referred to as ‘nominal growth’. These changes come about because of the combined effects of inflation and increases in the volume of health goods and services consumed.

Constant prices

Constant prices account for inflation by removing the effect of changes in prices over time. This means spending can be compared over different time periods. Constant price estimates indicate what spending would have been had the same prices applied across all years.

The process of generating constant prices is known as ‘deflating’ and price indexes (deflators) are used to calculate comparative prices. The result is a series of annual estimates of spending expressed in terms of the value of currency in a selected reference year. The reference year used in this report is 2021–22. More information on the price deflators used in this report can be found Concepts and definitions.

Growth in spending, expressed in constant prices, is referred to as ‘real growth’ or ‘growth in real terms’ and represents changes in the real value of the amount of money spent in a given year.

Types of spending

Spending can be broadly categorised as being recurrent or capital. Recurrent health spending is on goods and services consumed. In contrast, capital expenditure relates to spending on infrastructure such as buildings and medical equipment.

Recurrent spending

Recurrent spending is generally on goods and services consumed within a year that does not result in creating or acquiring fixed assets. Recurrent health spending includes health goods (such as medications and health aids and appliances); health services (such as hospital, dental and medical services); public health activities; and other activities that support health systems (such as research and administration).

Capital consumption or depreciation is included as part of recurrent spending.

Capital spending

Capital spending is on fixed assets like new buildings (such as hospitals) or medical equipment (such as CT scanners). It represents the cost of resources that last more than a year.

Overview

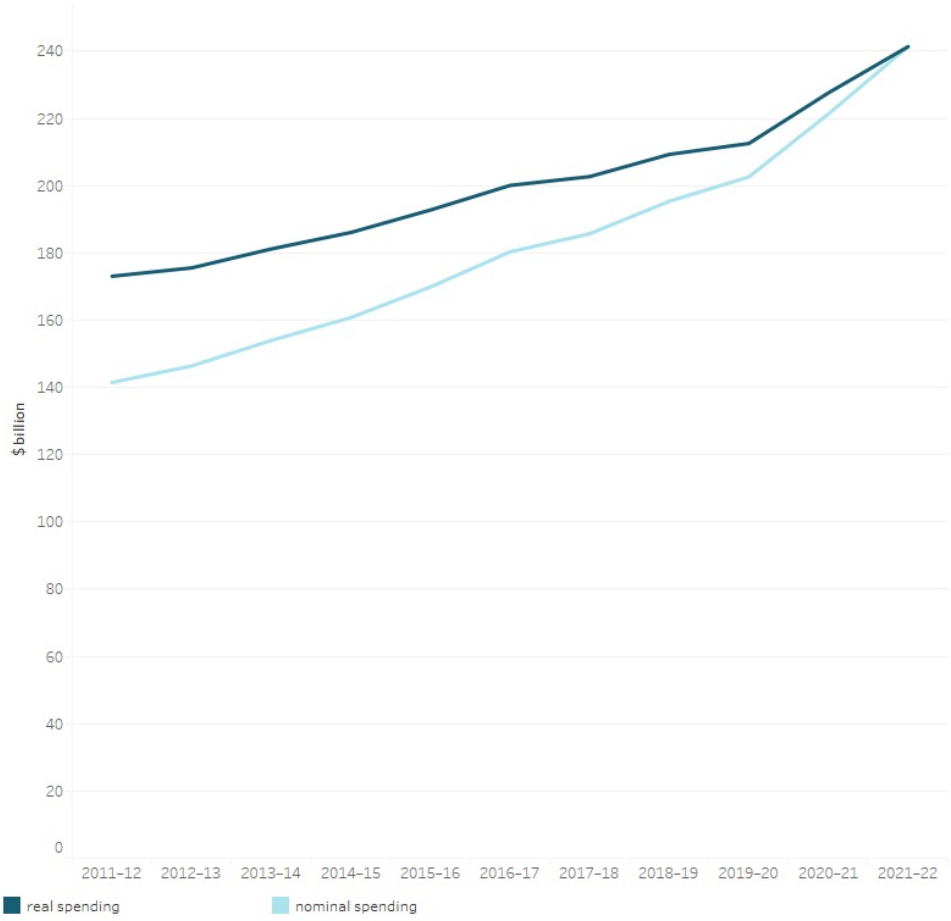
Overview

Estimates for total health spending capture the national aggregate of all spending on health goods and services for recurrent and capital purposes.

In 2021–22, Australia spent an estimated $241.3 billion on health. In real terms, this represented a 6.0% growth in spending from 2020–21, equating to an additional $13.7 billion (Figure 1a). While the growth was higher than the average over the decade from 2011–12 (3.4%), the 2021–22 value was broadly consistent with the longer-term trend. This suggests a 'continued rebound' in health spending since 2020–21 following a low growth during the early stages of the pandemic associated with activity restrictions in 2019–20 (Figure 1b). While the overall amount of spending might appear similar to previous trends, there were some signs of the pandemic impacting on the type of spending, particularly through COVID-19 vaccines and the government COVID-19 response funding arrangements.

Figure 1a: Nominal [(a)] and real [(b)] total health expenditure, 2011-12 to 2021-22

The line graph shows that total health spending in both current and constant prices increased each year from 2011–12 to 2021–22. Total health spending in current prices increased from $141.5 billion in 2011–12 to $241.3 billion in 2021–22. In the same period, total health spending in constant prices increased from $173 billion to $241.3 billion.



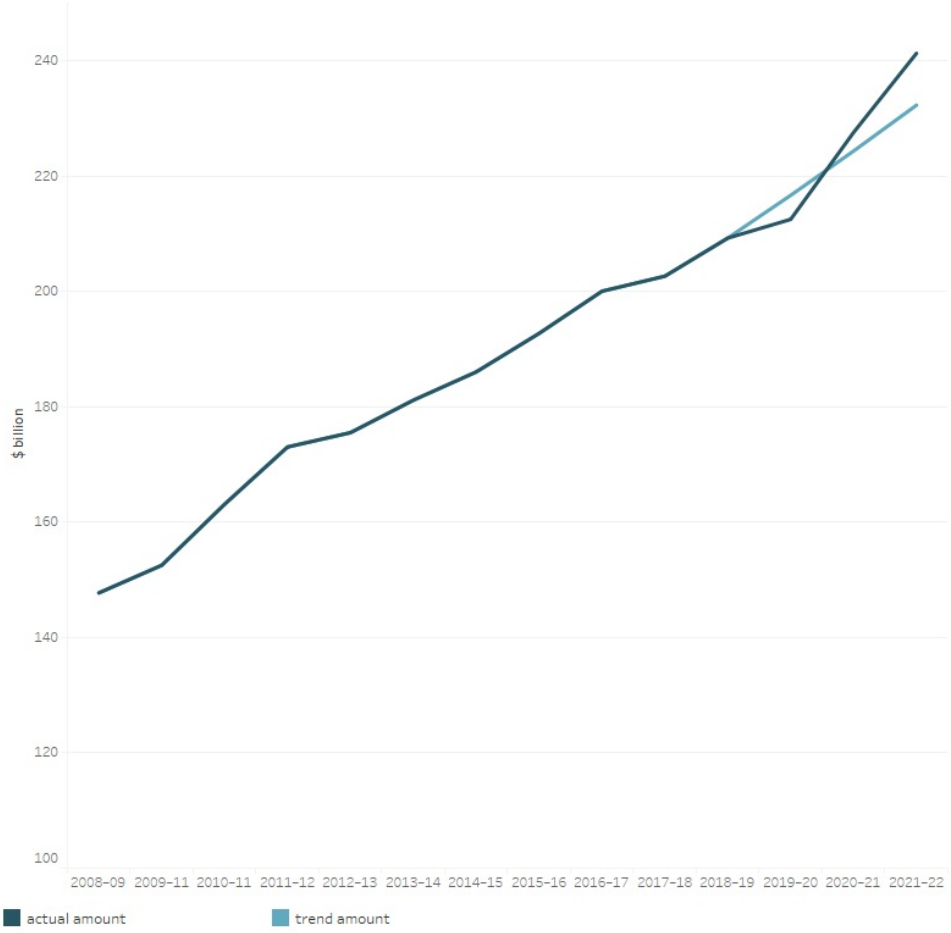
[(a)] Nominal spending refers to spending not adjusted for inflation from one year to another year.

[(b)] Real spending refers to spending accounted for inflation by removing the effect of changes in prices over year. Real health spending is in 2021–22 prices.

Source: AIHW Health Expenditure Database (Table 1).

Figure 1b: Total health spending, constant prices, during the COVID-19 pandemic (2019-20 to 2021-22) compared with the pre-pandemic period

The line graph shows the total health spending, in the three years during the COVID-19 pandemic (2019–20 to 2021–22) compared to the trend of the previous 10-year period (2008–09 to 2018–19). Assuming the average growth rate for the previous 10-year period remains the same for 2019–20 and 2021–22, the trend amounts of total health spending in constant prices for 2019–20, 2020–21 and 2021–22 were $216.7 billion, $224.4 billion, and $232.3 billion respectively. While the actual amounts for these years were $212.5 billion, $227.6 billion and $241.3 billion, respectively.



Notes:

1. Actual amount is the health spending in 2021–22 prices.
2. Trend amount refers to the heath spending in 2021–22 prices, following the trend of the previous 10-year period (assuming the average annual growth rate for the previous 10-year period remains the same for the period from 2019–20 to 2021–22).

Source: AIHW Health Expenditure Database (Table 1).

Government's COVID-19 Health Response

Following the beginning of the Novel Coronavirus (COVID-19) pandemic in late February 2020, the Australian Government entered a National Partnership Agreement — the National Partnership on COVID-19 response (NPCR) with state and territory governments. This agreement aims to provide financial assistance for the additional costs incurred by state and territory health services in responding to the COVID-19 outbreak, and efforts to minimise the spread of COVID-19 in the Australian community.

This agreement has three funding arrangements in 2021–22: (1) Hospital Services Payments, (2) State Public Health Payments, and (3) Private Hospital Financial Viability Payment.

In addition, governments implemented a range of policies and programs in response to the COVID-19 pandemic, including referred and unreferred medical services through MBS telehealth, mental health programs, public health mainly related to primary care respiratory clinics, COVID-19 testings and vaccinations (outside the NPCR), MBS-funded COVID-testing, distribution of masks and personal protective equipment (PPE) to health systems.

The main areas in which spending increased were:

- primary health care, by $8.3 billion (10.9% increase)
- hospitals, by $4.2 billion (4.6% increase)
- other services, by $1.3 billion (7.9% increase)
- referred medical services, by $0.4 billion (1.7% increase)
- research, by 0.3 billion (3.7% increase) (tables A5 and A6).

Find out more at:
Table A6: Total health expenditure, constant prices, by area of expenditure and source of funds, 2021–22 ($ million) (XLS 14KB)

Table A6: Total health expenditure, constant prices, by area of expenditure and source of funds, 2021–22 ($ million)

	Government						Non-government				
	Australian Government										
Area of expenditure	DVA	Health and other	Premium rebates	Total	State and local	Total	HIF	Individuals	Other	Total	Total health expenditure
Hospitals	1,032	30,435	3,457	34,925	43,837	78,762	9,660	3,491	4,095	17,246	96,008
Public hospital services	428	29,161	274	29,864	42,617	72,480	766	1,247	2,698	4,711	77,192
Private hospitals	604	1,274	3,183	5,061	1,220	6,281	8,894	2,244	1,397	12,535	18,816
Primary health care	748	39,267	1,105	41,120	14,739	55,860	3,088	22,401	2,779	28,268	84,128
Unreferred medical services	114	11,263	. .	11,377	. .	11,377	. .	933	1,279	2,211	13,588
Dental services	78	452	771	1,301	963	2,264	2,156	6,661	46	8,862	11,126
Other health practitioners	231	2,217	317	2,765	9	2,774	887	1,154	707	2,747	5,521
Community health and other	14	4,123	—	4,137	7,315	11,452	1	194	383	578	12,030
Public health	. .	9,112	. .	9,112	6,453	15,565	. .	75	263	337	15,903
Benefit-paid pharmaceuticals	312	11,484	. .	11,795	. .	11,795	. .	1,568	. .	1,568	13,363
All other medications	. .	616	16	632	. .	632	44	11,818	103	11,965	12,597
Referred medical services	648	17,966	622	19,236	. .	19,236	1,737	4,098	. .	5,835	25,071
Other services	389	3,011	1,078	4,478	5,688	10,165	3,012	3,665	278	6,955	17,120
Patient transport services	123	233	114	470	3,956	4,427	319	524	133	977	5,403
Aids and appliances	132	674	271	1,077	. .	1,077	757	3,125	140	4,022	5,099
Administration	134	2,104	693	2,930	1,731	4,662	1,935	16	5	1,956	6,618
Research	4	5,890	. .	5,895	919	6,814	. .	2	448	450	7,264
Total recurrent expenditure	**2,822**	**96,570**	**6,262**	**105,653**	**65,183**	**170,836**	**17,497**	**33,658**	**7,600**	**58,755**	**229,591**
Capital expenditure	. .	191	. .	191	4,974	5,165	. .	. .	6,559	6,559	11,724
Medical expenses tax rebate	. .	—	. .	—	. .	—	. .	—	. .	—	—
Total health expenditure	**2,822**	**96,761**	**6,262**	**105,844**	**70,157**	**176,001**	**17,497**	**33,658**	**14,160**	**65,315**	**241,316**

. . not applicable

— rounded to zero

Notes:

'Health and other' figures include Australian Government Department of Health and Aged Care's own programs, grants to states and territories (including National Health Reform grants, National Partnership of COVID-19 Response grants, PBS section 100 programs in public hospitals and other National Partnership Payments), funding by other Australian Government agencies (including Department of Defence, capital consumption, and others).

'HIF' figures include health spending by Health insurance providers.

'Other' figures include health spending funded by other non-government sources (such as injury compensation insurance providers, non-government sector capital spending, non-patient revenue of private hospitals, and other private spending on health and medical research).

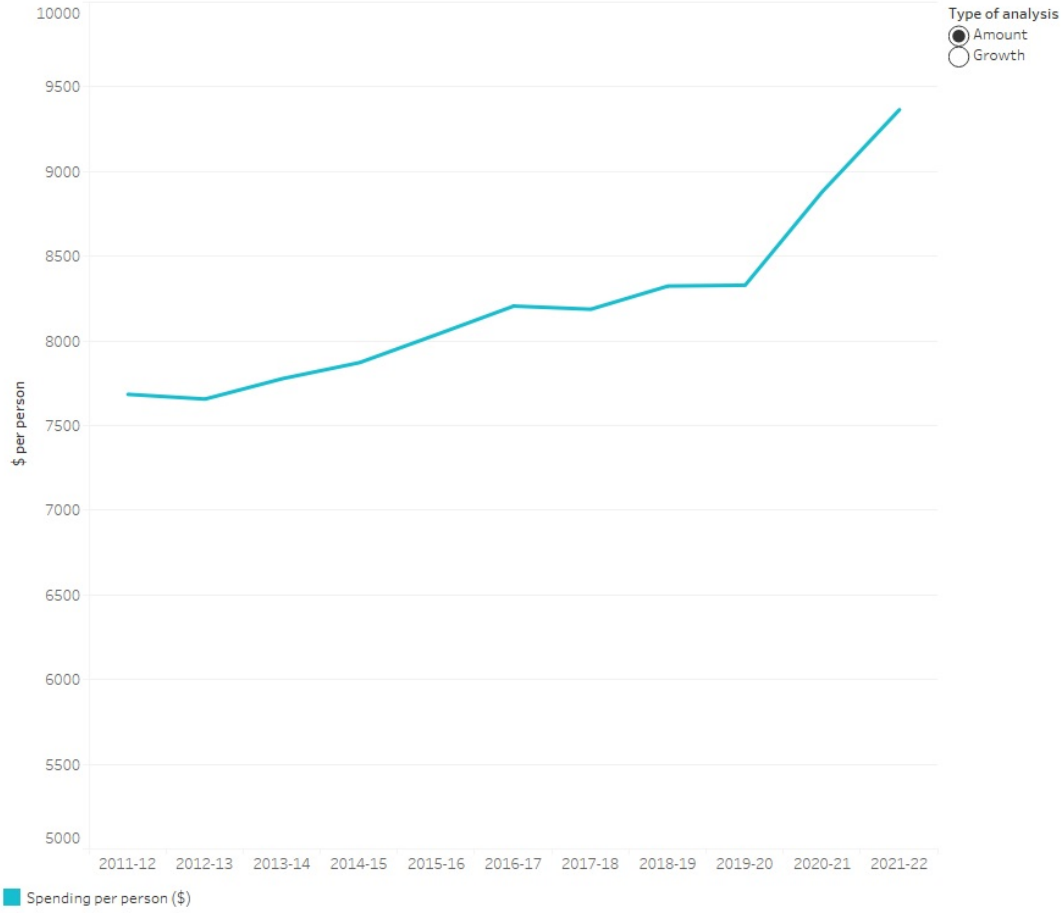
Overview

Taking into account population size and growth, average per capita spending on health in 2021–22 was $9,365. In real terms, this was $484 (5.4%) more per person than in 2020–21 (Figure 2a). Before 2020–21, per capita spending had grown with the modest rates of 1.7% in 2018–19 and 0.1% in 2019–20, then reached high growth rates in 2020–21 and 2021–22 of 6.6% and 5.4% respectively. The growth in per capita spending on health in 2021–22 was higher than the average yearly increase over the decade to 2021–22 (2.0%) and higher than might have been expected based on the background trend (between 2008–09 and 2018–19) (Figure 2b).

The continued increase in per capita spending in 2021–22 from the low base in 2019–20 can be attributed to the impact of the COVID-19 pandemic which resulted in increased health spending and decreased population growth. The growth rates of health spending in 2020–21 and 2021–22 were 7.1% and 6.0% respectively in real terms, higher than the average health spending growth (3.5%) during the pre-pandemic period (2008–09 to 2018–19). During the same period, population growth rates were around 0.5% which was lower than the average population growth rate (1.6%) over the pre-pandemic period.

Figure 2a: Average total health spending per person [(a)], and annual growth rate, constant prices [(b)], 2011-12 to 2021-22

The line graph shows that average total health spending per person in constant prices decreased from $7,684 in 2011–12 to $7,657 in 2012-13. It then increased to $9,365 in 2021–22. Annual growth rate in average total health spending per person ranged from –0.4 per cent and 6.6 per cent between 2011–12 and 2020–21 before decreased to 5.4 per cent in 2021-22. Annual growth rate in 2020–21 was 6.6 per cent, higher than the average annual growth rate in the last 5-year period.



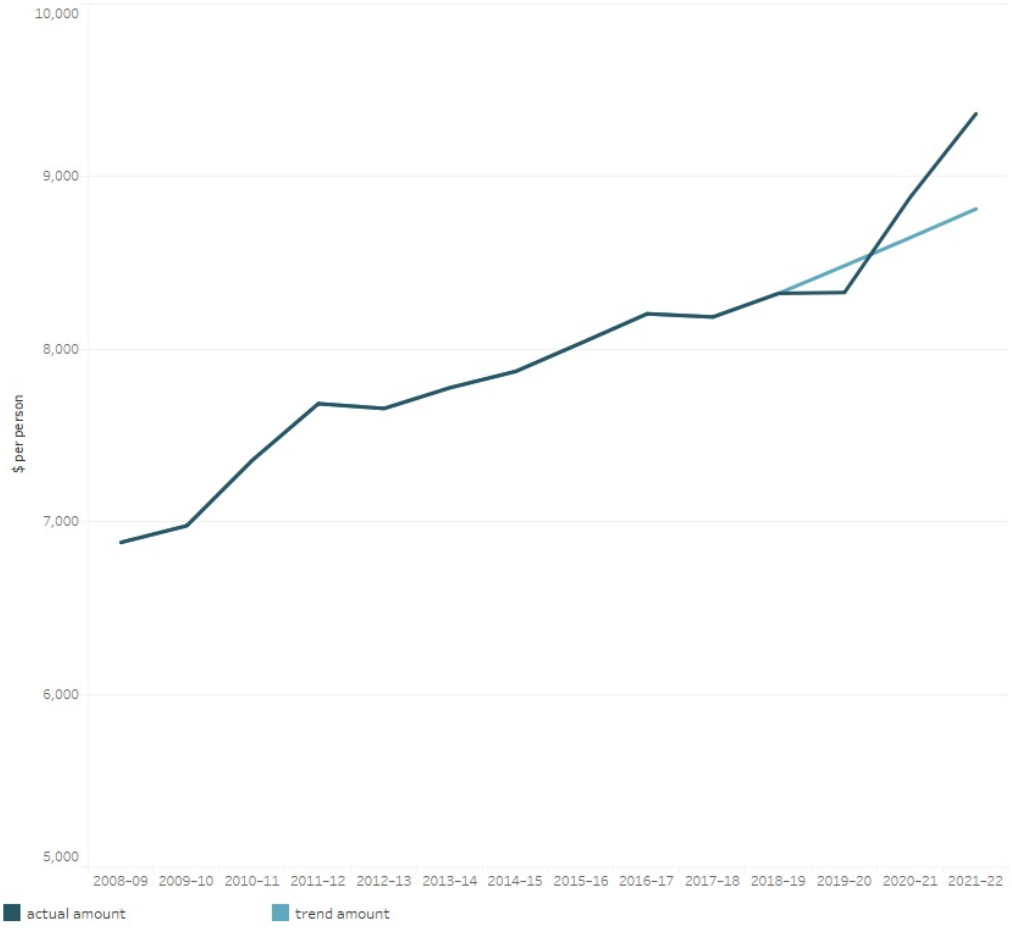
[(a)] Based on ABS annual estimated resident population (Table 37).

[(b)] Constant price health spending is in 2021–22 prices.

Source: AIHW Health Expenditure Database (Table 3).

Figure 2b: Average total health spending per person, constant prices, during the COVID-19 pandemic (2019–20 to 2021–22) compared with the pre-pandemic period

The line graph shows the average total health spending per person, in the three years during the COVID-19 pandemic (2019–20 to 2021–22) compared to the trend of the previous 10-year period (2008–09 to 2018–19). Assuming the average growth rate for the previous 10-year period remains the same from 2019–20 to 2021–22, the trend amounts of average total health spending per person in constant prices from 2019–20 to 2021-22 were $8,484, $8,647, and $8,813 respectively. While the actual amounts for these years were $8,329, $8,881 and $9,365 respectively.



Notes:

1. Actual amount is the health spending in 2021–22 prices.
2. Trend amount refers to the heath spending in 2021–22 prices, following the trend of the previous 10-year period (assuming the average annual growth rate for the previous 10-year period remains the same for the period from 2019–20 to 2021–22).
3. Based on annual estimated resident population (Table 37).

Source: AIHW Health Expenditure Database (Table 3).

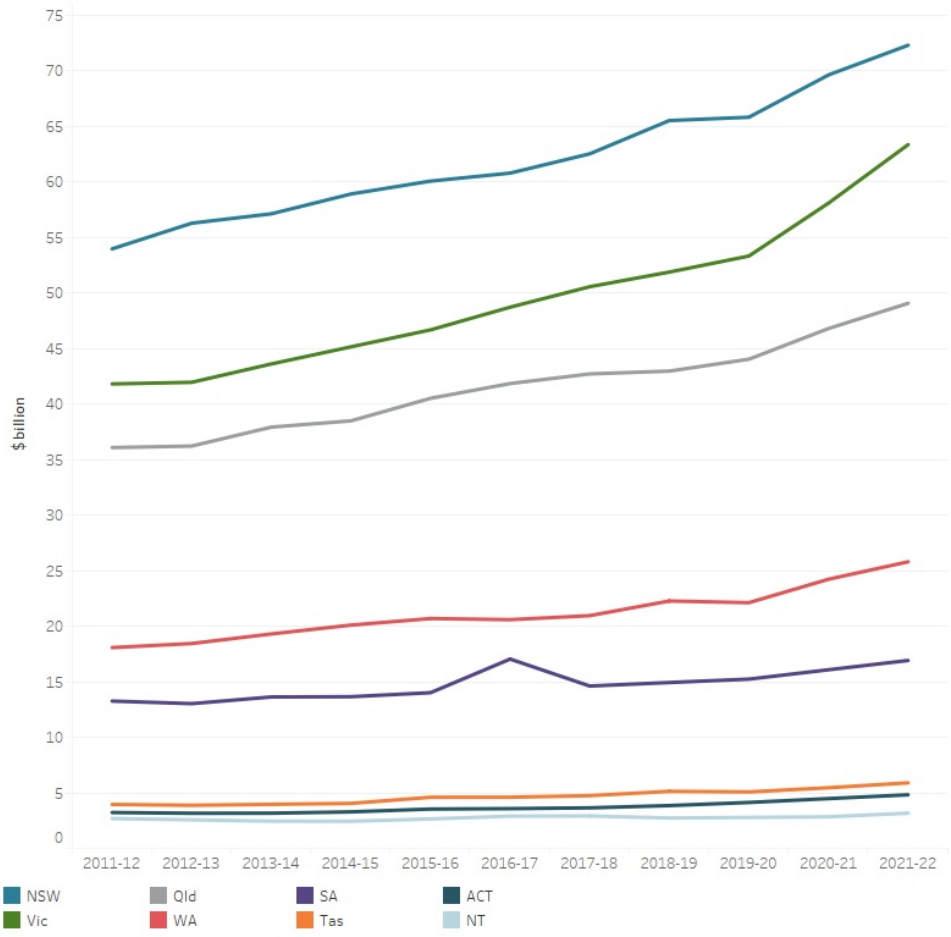
Overview

Of total health spending in 2021–22, more than half (56.2%) was spent in New South Wales ($72.3 billion) and Victoria ($63.3 billion) combined. These states also represented more than half (around 57%) of the Australian population (Figure 3; Table 37).

From 2020–21 to 2021–22, the growth in total spending ranged from 3.8% in New South Wales to 11.6% in the Northern Territory.

Figure 3: Total health expenditure for each state and territory, constant prices [(a)], 2011-12 to 2021-22

The line graph shows that total health spending was highest for New South Wales and lowest for the Northern Territory in the 10-year period. In 2021–22, total health spending was $72.3 billion for New South Wales and $3.2 billion for the Northern Territory. Total health spending increased between 2011–12 and 2021–22 for all states and territories.



(a) Constant price health spending is in 2021–22 prices.

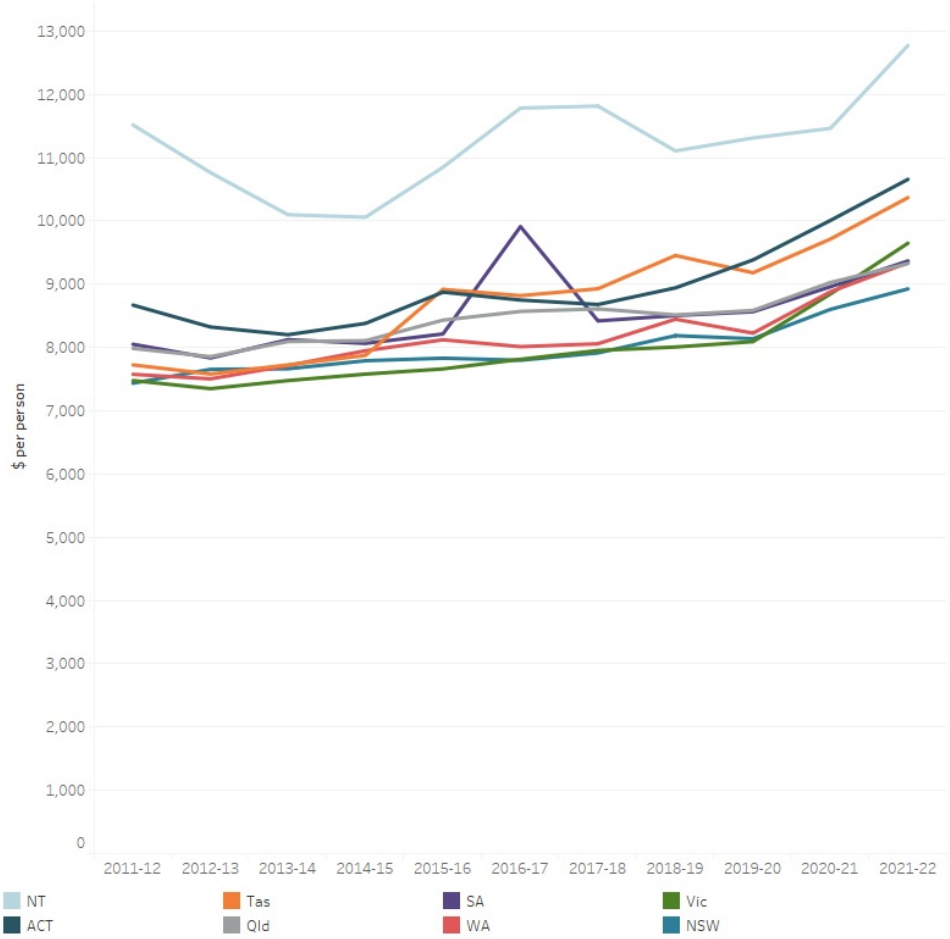
Note: Spending increased in 2016–17 for South Australia (SA) is due to a large one-off capital project.

Source: AIHW Health Expenditure Database (Table 4).

In 2021–22, average per capita health spending was similar across all states and territories, except for the Northern Territory where average spending was $12,773 per person, compared with the national average of $9,365 (Figure 4).

Figure 4: Average total health expenditure per person [(a)] for each state and territory, constant prices [(b)], 2011-12 to 2021-22

The line graph shows that average total health spending per person for each state and territory increased overall from 2011–12 to 2021–22. Australian Capital Territory is excluded from the graph, as the Australian Capital Territory population is not an appropriate denominator. In the 10-year period, Northern Territory maintained the highest average total health spending per person while the other states and territories recording similar values.



(a) Based on ABS annual estimated resident population (Table 37).

(b) Constant price health spending is in 2021–22 prices.

Notes

1. The ACT per person figures need to be treated cautiously, since a large volume of ACT spending are for NSW residents; The ACT population is therefore not an appropriate denominator.
2. Spending increased in 2016–17 for SA due to a large one-off capital spending project.

Sources: AIHW Health Expenditure Database; Australian Bureau of Statistics (ABS 2023a) (Table 5).

Overview

On this page

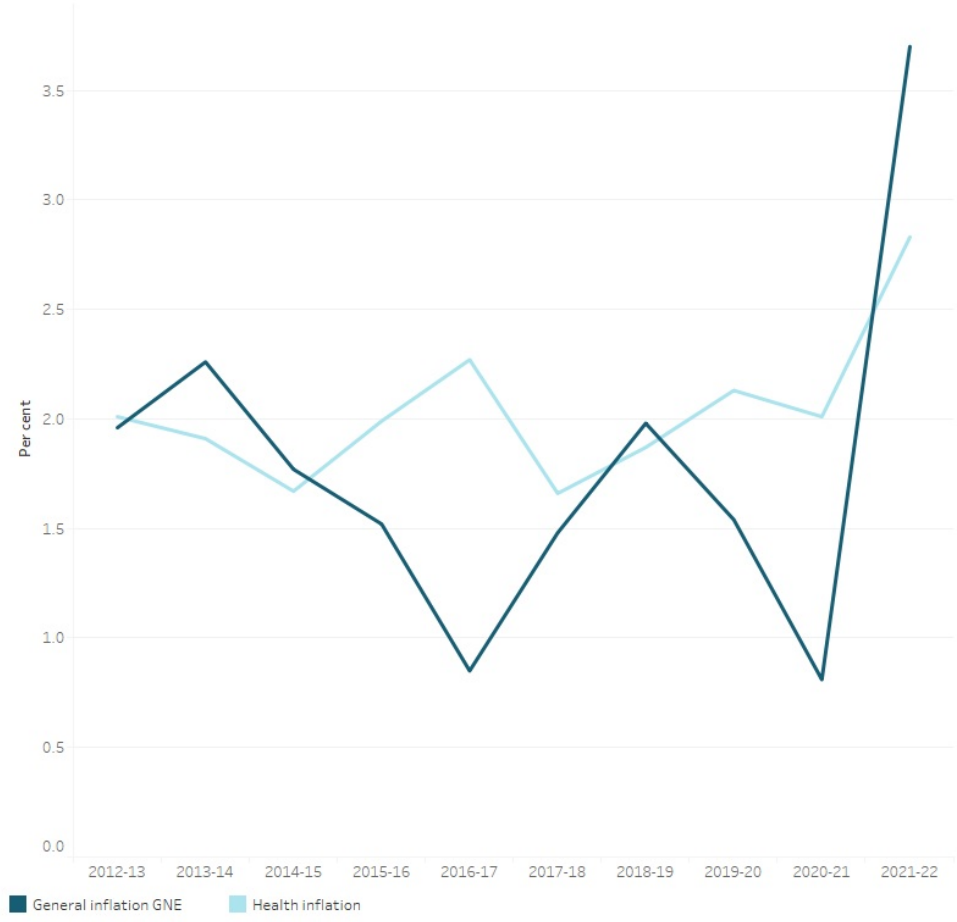
Health prices

It can be useful to understand how much changes in health spending are related to price changes (e.g. inflation) rather than the volume or nature of services being purchased and how this compares with the general economy. Between 2020–21 to 2021–22, health prices grew by 2.83% on average. This is broadly consistent with yearly health inflation over the past decade, which has fluctuated between 1.7% and 2.83%. General inflation, measured using the implicit price deflator (IPD) for gross national expenditure (GNE), was 3.7%. As such, 'excess health inflation' was –0.84%, indicating that prices in the general economy were rising slightly faster than prices of health goods and services (Figure 5).

Over the decade to 2021–22, prices in the health sector grew at an annual growth rate of 2.04% compared with prices in the broader economy with a yearly growth rate of 1.78%. This resulted in varying levels of excess health inflation, ranging from –0.84% in 2021–22 to 1.41% in 2016–17.

Figure 5: Annual health inflation [(a)] and general inflation [(b)] rates, 2011–12 to 2021–22

The line graph shows that annual health inflation rates were more stable than annual general inflation rates from 2011–12 to 2021–22. Annual health inflation rates using GDP IPD ranged from 1.67 and 2.83 per cent, while annual general inflation rates using the GNE IPD varied from 0.81 per cent and 3.7 per cent during this period. Annual health inflation increased overall from 2.01 per cent in 2020–21 to 2.83 per cent in 2021–22.



[(a)] Health inflation based on the AIHW Total Health Price Index.

[(b)] General inflation based on the IPD for GNE.

Sources: AIHW Health Expenditure Database; Australian Bureau of Statistics (ABS 2023b) (Table 6).

Inflation and deflators

Inflation refers to changes in prices over time. It can be positive (prices are rising over time and the same volume of goods cost more, so money is losing value) or negative (the same volume of goods is costing less).

Inflation in the broader economy is measured using price indexes, also known as deflators. These show the amount a price has changed over time relative to a base year. The reference year, or base year, for the deflators used in this report is 2021–22.

Health inflation

Health inflation is a measure of the average rate of change in prices within the health goods and services sector of the economy.

See Concepts and definitions: Deflators for more information on health deflators and industry-wide deflators.

General inflation

General inflation refers to the average rate of change in prices throughout the economy over time. There are different ways to measure the economy, and many methods for deriving deflators. The specific deflator can affect whether prices in the health sector appear to have risen slower or faster than the general inflation rate (excess health inflation).

In this report, the measure used for this is the IPD for GNE. GNE is a measure of the value of final expenditures on the goods and services purchased in the economy by all parties including governments and including imports but excluding exports. IPD is an indicator of changes in the purchase price of these goods.

Excess health inflation

Excess health inflation is the amount by which the rate of health inflation exceeds general inflation. Excess health inflation will be positive when health prices are rising more rapidly than prices generally throughout the economy. It will be negative when the general level of prices throughout the broader economy are rising more rapidly than health prices.

Health spending and gross domestic product

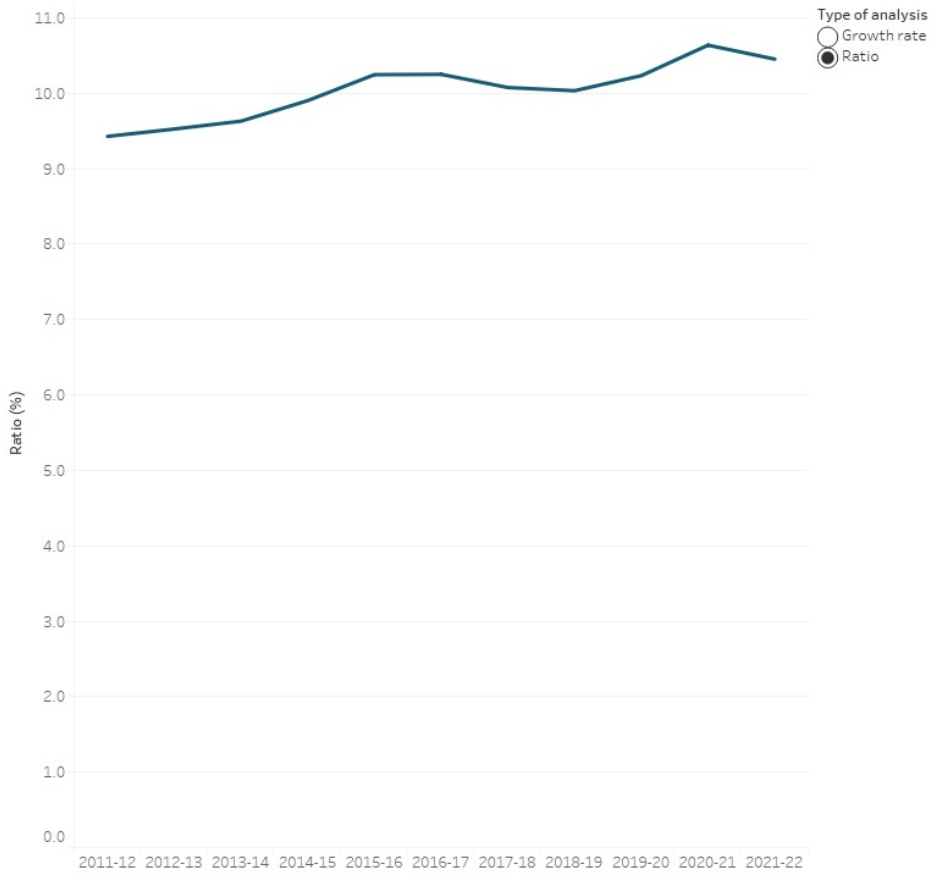
The ratio of health spending to GDP, showing the proportion of total economic activity represented by the health sector, is an indicator of the contribution of health spending to the overall economy.

In 2021–22, health spending accounted for 10.5% of GDP in Australia, approximately 0.2 percentage points lower than in 2020–21 (Figure 6). The ratio of total health spending to GDP increased gradually during the first half of the decade (2011–12 to 2016–17), then flattened out. It increased in the past two years, reaching to 10.6% in 2020–21 before decreasing in 2021–22.

See International comparison of health spending for comparing the ratios of the health spending to GDP among OECD countries.

Figure 6: Ratio of total health expenditure to GDP, and annual growth rate, current prices, 2011-12 to 2021-22

The line graph shows that annual growth rates in Gross Domestic Product (GDP) is more volatile compared to the annual growth rates in total health spending from 2011–12 to 2021–22. Annual growth rates in total health spending ranged from 1.3 per cent to 7.1 per cent. Meanwhile, annual growth rates in GDP ranged from -0.1 per cent to 3.7 per cent and with an average growth rate over the decade up to 2021–22 of 2.3 per cent. In this 10-year period, the ratio of health spending to GDP was relatively consistent and increased overall from 9.4 per cent in 2011–12 to 10.5 per cent in 2021–22.



Sources: AIHW Health Expenditure Database; Australian Bureau of Statistics (ABS 2023b) (Table 7).

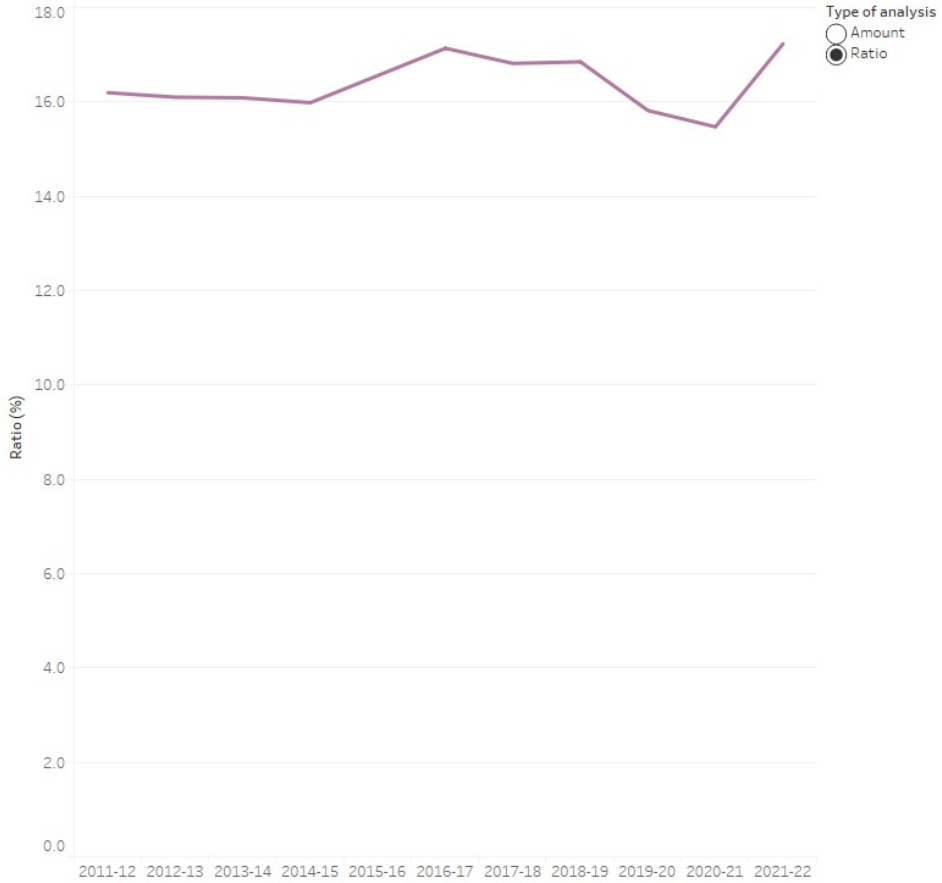
Overview

The ratio of government health spending to total government expenses provides a broad indication of the amount of government financial resources being dedicated to health over time, how this compares with other sectors and how the mix of revenue sources being used to fund health is changing. In this context, comparisons to total government spending represents total government resourcing in terms of both tax revenue and other sources, including borrowing.

In 2021–22, government health spending was $176.0 billion, which accounted for 17.2% of total government expenses, approximately 1.8 percentage points higher than 2020–21 (Figure 7). This is attributed to total government expenses growing slower than health spending (1.1% compared with 12.6% over 2021–22, in nominal terms).

Figure 7: Ratios of government health spending to government expenses, current prices, 2011-12 to 2021-22

The line graph shows that total government health spending, and government expenses increased from 2011–12 to 2020–21. Total government health spending increased from $99.1 billion in 2011–12 to $176.0 billion in 2021–22. In addition, total government expenses were higher than total government health spending and increased from $611.8 billion in 2011–12 to $1,021.8 billion in 2021–22. During this period, total government health spending to government expenses ratio ranged from 15.5 per cent to 17.2 per cent.



Note: Government expenses include the total expenses of Commonwealth government, state governments and local governments.

Sources: AIHW Health Expenditure Database; Australian Bureau of Statistics (ABS 2023c) (Table 9).

More details on the Australian Government's Economic Response to COVID-19 can be found at Supporting individuals and households while state and territory government programs can be found in their specific websites. More on the relationship between tax revenue and government expenses can be found in the box below.

Government expenses

Taxation revenue is a major source of income used by governments to fund expenses. However, tax revenue is the only way that governments fund public expenses, including health spending. Government expenses can also be funded through borrowing and other forms of revenue generation, such as licence fees, charges for goods and services, fines and return on government's assets.

The Australian Government raises revenue through taxing individuals and businesses, including through:

- personal income tax
- goods and services tax (GST), for which all revenue is distributed to states and territories
- company tax.

State and territory governments receive funds from the Australian Government, but also collect taxes, such as stamp duty on the purchase of a house or taxes on payrolls.

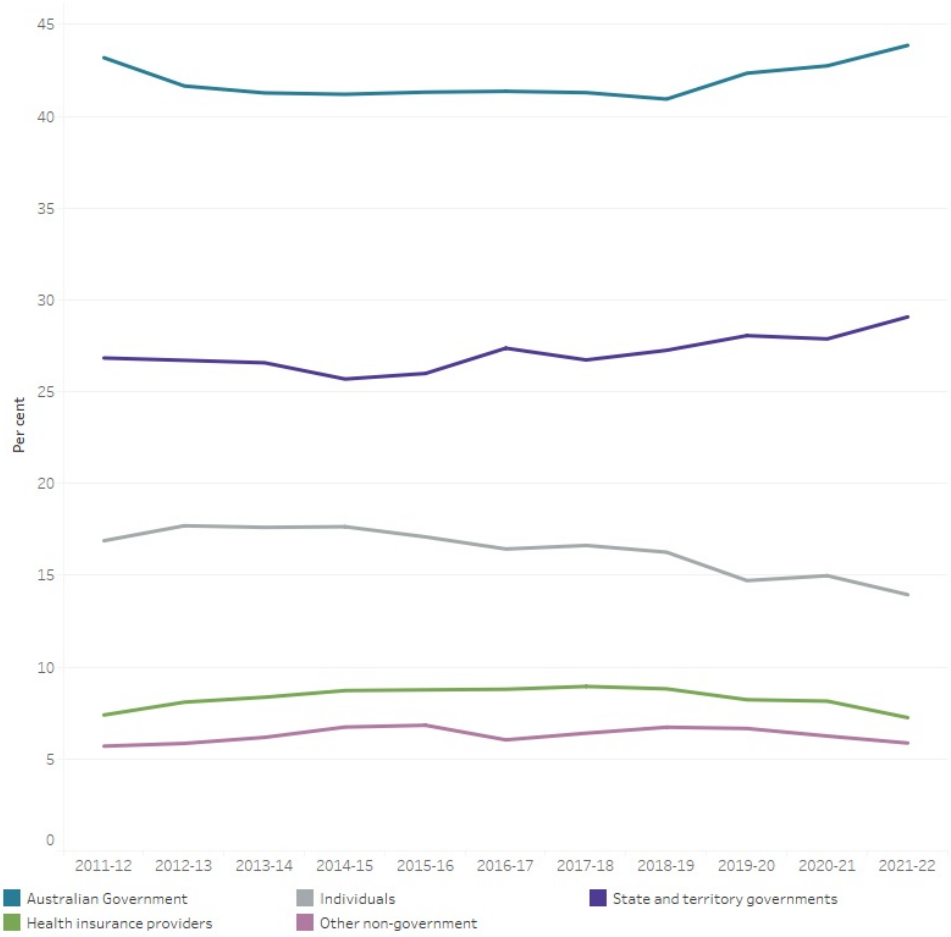
Apart from health spending, other purposes of government expenses include social protection, general public services, economic affairs, defence, education, public order and safety, environmental protection, recreation, culture and religion, and transport (see ABS 2023c).

Spending trends by source

During 2021–22, total health spending was $241.3 billion. Of this, more than two-thirds (72.9% or $176.0 billion) was government funded (43.9% by the Australian Government and 29.1% from state and territory governments). The remaining 27.1% ($65.3 billion) was funded by non-government sources (Figure 8).

Figure 8: Proportion of total health spending by source of funds, current prices, 2011-12 to 2021-22

The line graph shows that the proportions of total health spending by source of funds remained relatively stable between 2011–12 and 2021–22. The Australian Government and state and territory governments funded majority of total health spending in 2021–22, with each source funding 43.9 per cent and 29.1 per cent respectively. Non-government sources made up the rest with individuals, health insurance providers and other non-government sources funding 13.9 per cent, 7.3 per cent and 5.9 per cent respectively in 2021–22.



Note: Other non-government refers to spending on health goods and services by injury compensation insurers and other sources of private income.

Source: AIHW Health Expenditure Database (Table 10).

Spending trends by source

On this page:

Australian Government spending

In 2021–22, Australian Government health spending was $105.8 billion, representing a $8.4 billion real increase (8.6%) from 2020–21 (Table 10). This was more than double the average annual real growth in the decade to 2021–22 (3.5%) and also higher than 2020–21 (7.6%).

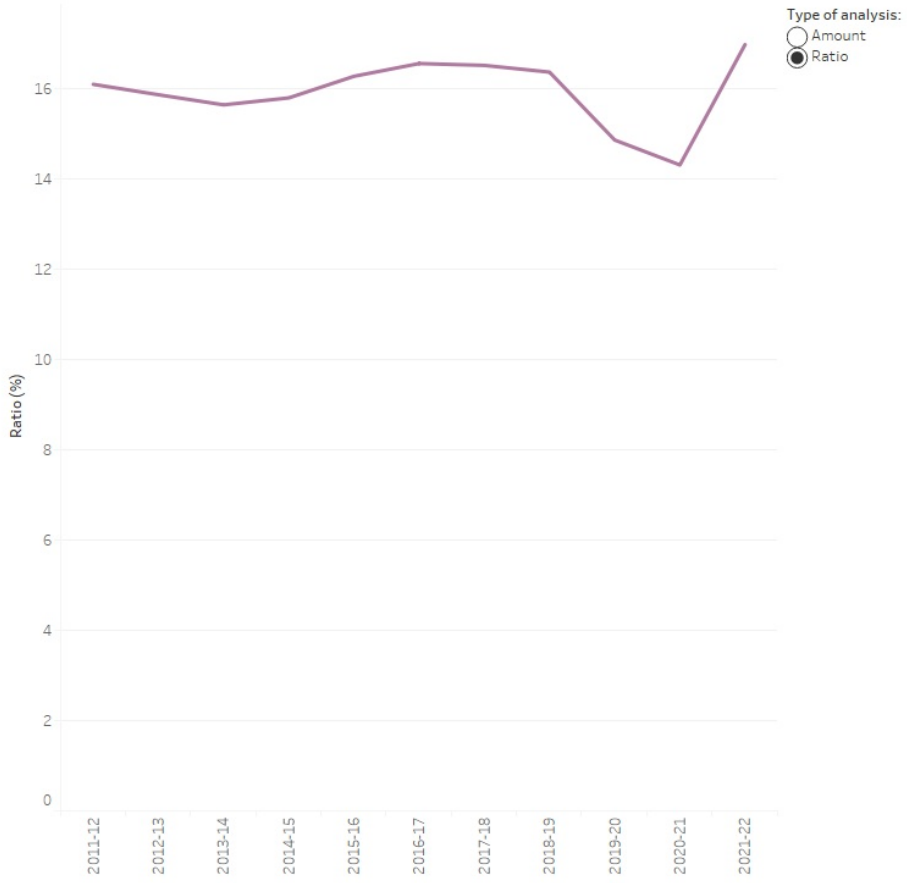
The growth of Australian Government spending between 2020–21 and 2021–22 was due mainly to increases in direct Australian Government spending (10.1%) and grants to states and territories (9.2%) while the health spending associated with the health insurance premium rebate decreased by 1.9% and DVA spending decreased by 5.1% (Table 12). Among the direct Australian Government spending, the biggest increases were in public health (including spending on COVID-19 vaccines, anti-viral treatments and rapid antigen tests) and referred medical services (including diagnostic imaging, specialist services, among others).

Spending relative to government expenses

During 2021–22, the $105.8 billion health spending by the Australian Government was 17.0% of its expenses, approximately 2.7 percentage points higher than in 2020–21 (Figure 9). This is attributed to Australian Government nominal health spending growing faster than other areas of Australian Government spending (Table 11). More details on the Australian Government's Economic Response to COVID-19 can be found on the Treasury website.

Figure 9: Ratio of Australian Government health spending to Australian Government expenses, current prices, 2011-12 to 2021-22

The line graph shows the dollar amounts of the Australian Government expenses, and health spending with one additional line showing the ratios of the Australian Government health spending to government expenses as a percentage. Australian government health spending increased from $61.1 billion in 2011–12 to $105.8 billion in 2021–22. Government expenses increased from $379.3 billion in 2011–12 to $623.1 billion in 2021–22. The highest ratio of 17.0 per cent was in 2021–22 and the lowest one was 14.3 per cent in 2020–21.



Sources: AIHW Health Expenditure Database; Australian Bureau of Statistics (ABS 2023c) (Table 11).

Spending programs

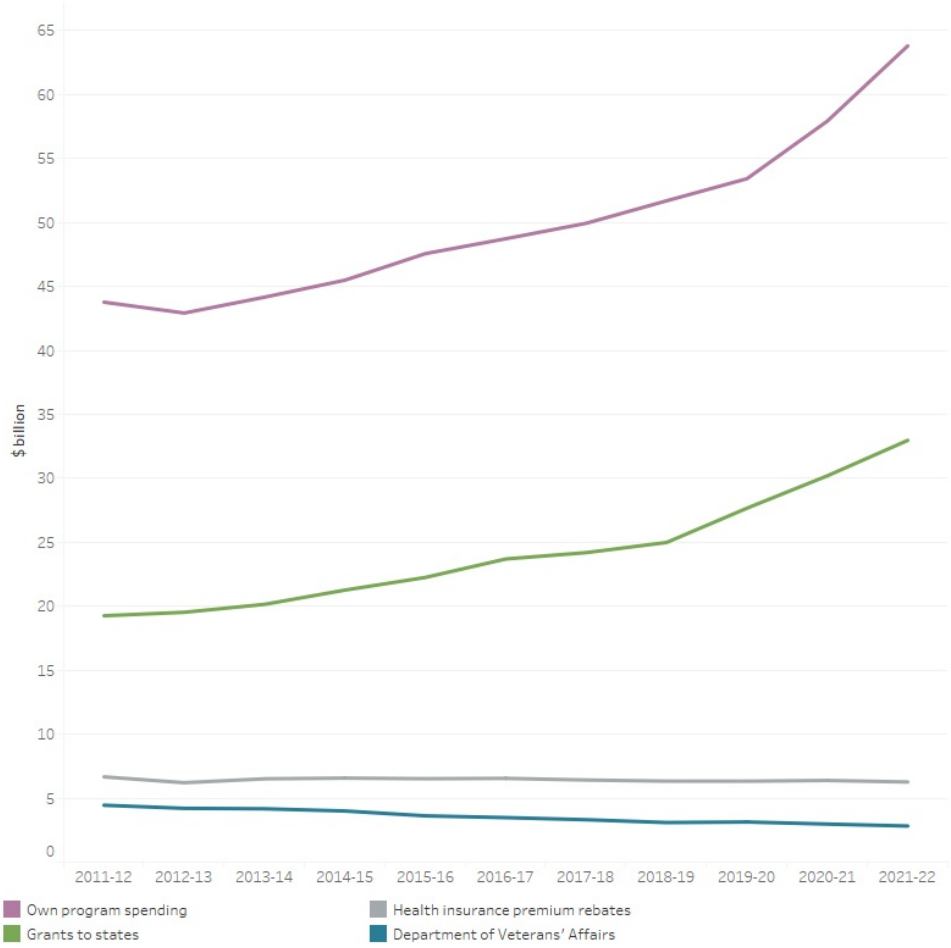
Australian Government spending in 2021–22 (Figure 10) comprised:

- direct Australian Government spending ($63.8 billion, or 60.3%), mostly administered through the Department of Health and Aged Care (DoHAC) on programs for which the government has responsibility, such as the MBS, PBS, and health research. This also includes some health spending by the Department of Defence ($568 million).
- grants to states and territories ($33.0 billion, or 31.1%), including National Health Reform funding (mainly comprising public hospital funding), National Partnership on COVID-19 Response (NPCR), other National Partnership Payments (NPPs) and the PBS Section 100 funding in public hospitals.
- rebates and subsidies for privately insured people under the national Private Health Insurance Act 2007 ($6.3 billion, or 5.9%)
- DVA funding for goods and services provided to eligible veterans and their dependants ($2.8 billion, or 2.7%)

The 8.6% increase in Australian Government health spending between 2020–21 and 2021–22 can be attributed to increases in spending through specific DoHAC programs ($5.9 billion increase) and funding to states and territories through grants ($2.8 billion increase). The main driver of this increase was COVID-19 related health spending funded by the Australian Government such as spending on COVID-19 vaccines, rapid antigen tests, and personal protective equipment.

Figure 10: Australian Government total health spending by program, constant prices [(a)], 2011–12 to 2021–22

The line graph shows that from 2011–12 to 2021–22 the Australian Government spent the most to least on their own program spending, grants to states, health insurance premium rebates and Department of Veterans' Affairs. Over the 10-year period, there was an overall increase in health spending by the Australian Government for each program excluding on Department of Veterans' Affairs. In 2021–22, The Australian Government spent $63.8 billion on own program spending, $33.0 billion on grants to states, $6.3 billion on health insurance premium rebates and $2.8 billion on Department of Veterans' Affairs.



(a) Constant price health spending is in 2021–22 prices.

Notes:

1. Australian Government own program spending, mostly administered through the Department of Health and Aged Care on programs for which the government has responsibility, such as the MBS, PBS, health research and capital consumption. This also includes some health spending by the Department of Defence since 2019–20
2. Grants to states include the Commonwealth Government National Health Reform funding, National Partnership on COVID-19 Response (NPCR), other National Partnership Payments (NPPs) and the funding of PBS section 100 programs in public hospitals.
3. Spending on the medical expenses tax rebate is not included.
4. Tax revenue has been deducted from Australian Government own program spending.

Source: AIHW Health Expenditure Database (Table 12).

COVID-19 related health spending funded by the Australian Government in 2021-22

The pandemic impacted health spending in many ways, often through increasing the cost and complexity of service delivery in ways that are difficult to quantify. There were, however, some large COVID-19-specific response programs, such as the National Partnership on COVID-19 Response (NPCR) and spending on COVID-19-related programs by the Australian Government Department of Health and Aged Care (DoHAC, including Medicare Benefits Scheme (MBS) and Pharmaceutical Benefits Scheme (PBS)).

During 2021–22, there was an estimated $18.7 billion spent through these programs ($6.6 billion on the NPCR and $12.1 billion on the DoHAC programs).

Spending on the National Partnership on COVID-19 Response

During 2021–22, the Australian Government spending through the NPCR was $6.6 billion. This comprised

- hospital services payments ($1.9 billion, or 28.4%)
- state public health payments ($4.3 billion, or 64.9%)
- private hospital financial viability payment ($0.4 billion, or 6.7%).

Australian Government spending through DoHAC programs

In 2021–22, DoHAC spending on specifically identifiable COVID-19 programs was estimated to be $12.1 billion. The distribution of the spending in 2021–22 included:

- 44.4% (5.4 billion) on COVID-19 vaccinations (mainly provided access to, and delivery of, COVID-19 vaccines)

- 31.0% ($3.8 billion) on COVID-19-related medical services (mainly related to COVID-19 vaccine suitability assessment services, as well as other referred and unreferred medical services through MBS-funded telehealth)
- 9.2% ($1.1 billion) on COVID-19 testing (mainly through MBS-funded COVID-19 testing including rapid antigen test kits)
- 8.4% ($1.0 billion) on COVID-19 medical goods and equipment (mainly related to distribution of masks and personal protective equipment products for the national medical stockpile)
- 6.8% ($0.8 billion) on Other COVID-19-related health spending (largely related to mental health programs, and public health mainly related to primary care respiratory clinics)
- 0.3% ($34 million) on COVID-19-related investments.

Note that COVID-19 related spending for residential aged care is outside the scope of this report. This also does not include COVID-19 related spending by other Australian Government agencies, which might fall into a broader scheme of economic response to COVID-19 .

MBS, PBS and RPBS government benefits paid in 2021-22

In 2021-22, the Australian Government funded $28.6 billion as government benefits paid for MBS services.

During the same year, the Australian Government funded $12.1 billion as subsidies for PBS and $0.3 billion for RPBS pharmaceuticals.

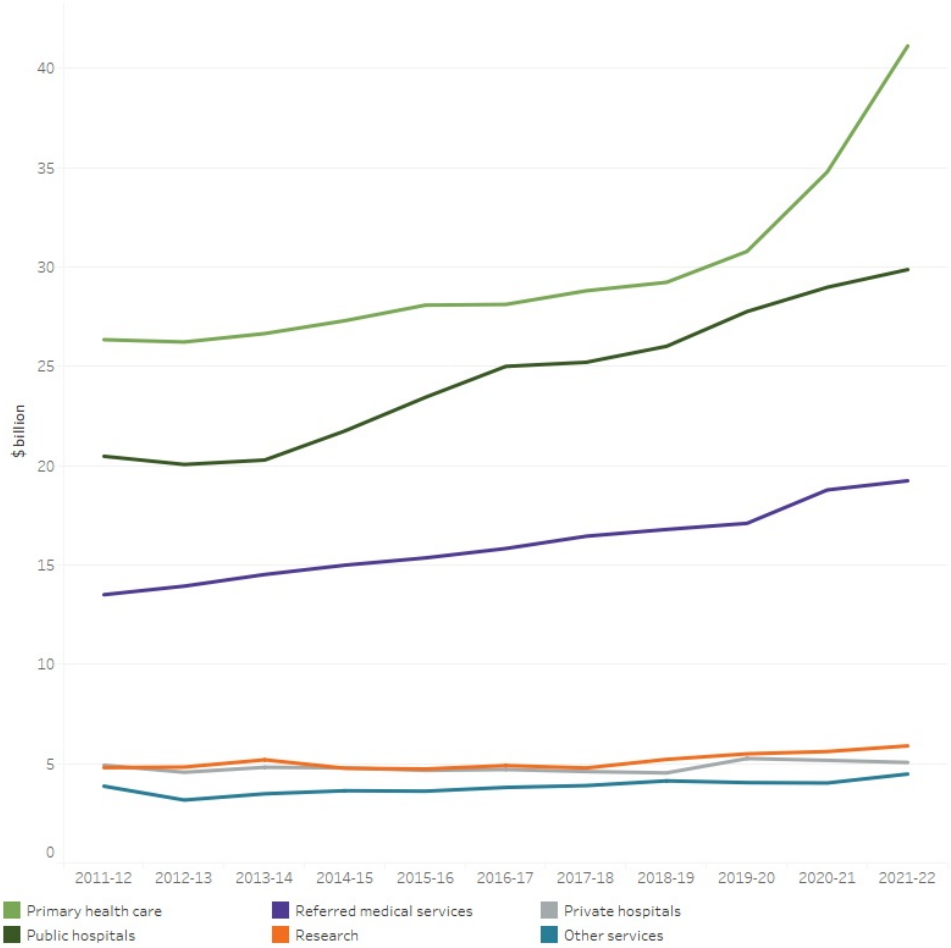
Area of spending

During 2021-22, more than one-third (38.8%) of Australian Government health spending was for primary health care ($41.1 billion) (Figure 11). Of this:

- pharmaceuticals subsidised through the PBS (not including Section 100 drugs and other drugs that could be allocated to the areas of public hospital services and private hospitals) contributed $11.8 billion.
- unreferred medical services (mainly visits to a general practitioner) was $11.4 billion.
- public health was $9.1 billion.
- other health practitioners was $2.8 billion (Table A6).

Figure 11: Australian Government health spending, by area of spending, constant prices [(a)], 2011-12 to 2021-22

The line graph shows that from 2011-12 to 2021-22 Australian Government health spending increased in public hospitals, primary health care, referred medical services, research and other services. In 2021-22, health spending was $41.1 billion on primary health care, $29.9 billion on public hospitals, $19.2 billion on referred medical services, $5.9 billion on research, $5.1 billion on Private hospitals, $4.5 billion on Other services, and $191 million on capital.



[a] Constant price health spending is in 2021–22 prices.

Notes:

1. Other services include patient transport services, aids and appliances, and administration.
2. Spending on the medical expenses tax rebate and capital is not included.

Source: AIHW Health Expenditure Database (Table 13).

Spending on public hospitals was the next largest area of Australian Government health spending (between $29.9 billion and $31.5 billion depending on how some MBS benefits for services provided in public hospitals are treated), followed by referred medical services ($19.2 billion or $16.0 billion also depending on how some MBS spending is treated) (Figure 11, Table A11b).

The estimated spending on public hospitals and referred medical services by the Australian Government is represented as a range here to reflect additional components of MBS spending that have not historically been treated as public hospital spending in the national health accounts methodology but that are believed to be related to services provided in public hospitals.

MBS funding by the Australian Government in public and private hospitals

The lower bound of $29.9 billion of the Australian Government spending on public hospital services includes spending by the Department of Veteran's Affairs (DVA), National Health Reform funding, PBS section 100 programs (Highly Specialised Drugs, PBS Efficient Funding of Chemotherapy program, Chemotherapy Pharmaceutical Access Program (CPAP) and the Special Authority Program (trastuzumab - Herceptin), Botulinum Toxin Program, and Human Growth Hormone program) delivered through hospitals, a small grouping of other National Partnership Payments, an allocation of the private health insurance premium rebates, some specific programs administered by the Australian Government Departments of Health and Defence and capital consumption allocated to public hospitals. More details can be found in Table A11.

This amount currently does not include:

(i) Government benefits paid for in-hospital MBS, mostly for private patients in public and private hospitals. This includes both inpatients and outpatients (at public hospitals' outpatient clinics). The majority of these components are currently allocated to Referred medical services. This is primarily because limitations in the MBS data mean public hospital spending cannot be directly derived, including:

(i.1) Only MBS payments for medical services provided to admitted patients are flagged as 'in hospital'. Outpatient and non-medical services are not recorded as hospital services.

(i.2) MBS 'in-hospital' services cannot be differentiated by services provided to private patients in a private hospital versus services provided to private patients in a public hospital.

(i.3) In addition, MBS payments are generally made to individual patients and individual practitioners, rather than directly to hospitals. There are, however, arrangements in place, particularly between practitioners and hospitals, that can mean that part or all of the MBS benefits are passed on to the hospital in lieu of payments from patients or fees for private practice arrangements for practitioners in public hospitals. A lack of detail regarding exactly who ultimately receives the MBS benefits and these payments are treated in data provided by both the Australian Government and the states and territories has meant that there is currently no consensus as to how best to treat this revenue in the ANHA.

While these limitations currently prevent the full incorporation of these MBS components into the area of public and private hospital spending, the AIHW has worked and will continue to work with the HEAC to develop a method for quantifying the amount of spending involved for the MBS components and to better understand the likely flow-on impact for other spending categories such as referred medical services and benefit-paid pharmaceuticals.

The estimated quantities of these components are provided below for both public and private hospitals. This does not include an estimate of the non-medical components for the MBS for private hospitals as there is no data currently available to quantify this.

In terms of the flow-on impacts, the full inclusion of this new way of categorising this spending into the ANHA would result in reductions to the estimates for referred medical services (as spending is reallocated to hospitals) in addition to increasing the Australian Government contributions for both public and private hospitals.

The full inclusion would also be likely to result in reductions to public hospital spending estimates for Individuals and potentially State and territories, however the full effects require further work with HEAC to determine.

Private hospitals spending would not be associated with the same degree of flow-on issues because the current estimation methods already exclude these amounts.

Table: Estimates of Australian Government's spending in public and private hospitals, including in-hospital MBS, 2021-22 ($ million)

	Current figure	MBS for admitted patients	MBS for non-admitted patients	Total estimates

Public hospitals	29,864	734	865	31,462
Private hospitals	5,061	2,459	0	7,521
Total hospitals	34,925	3,193	865	38,982

The AIHW is continuing to work with data providers and HEAC to resolve outstanding issues and fully incorporate these new estimates into the ANHA.

Using the current estimates, the rise in total Australian Government spending between 2020–21 and 2021–22 was mostly due to an increase of $6.3 billion on primary health care (mostly public health by $4.9 billion, including spending on COVID-19 vaccines, rapid antigen tests, personal protective equipment; community health and other by $1.7 billion), public hospitals by $0.9 billion, referred medical services by $0.5 billion (including spending on COVID-19 testings, diagnostic imaging, specialist services, among others), and other services by $0.5 billion (Figure 11).

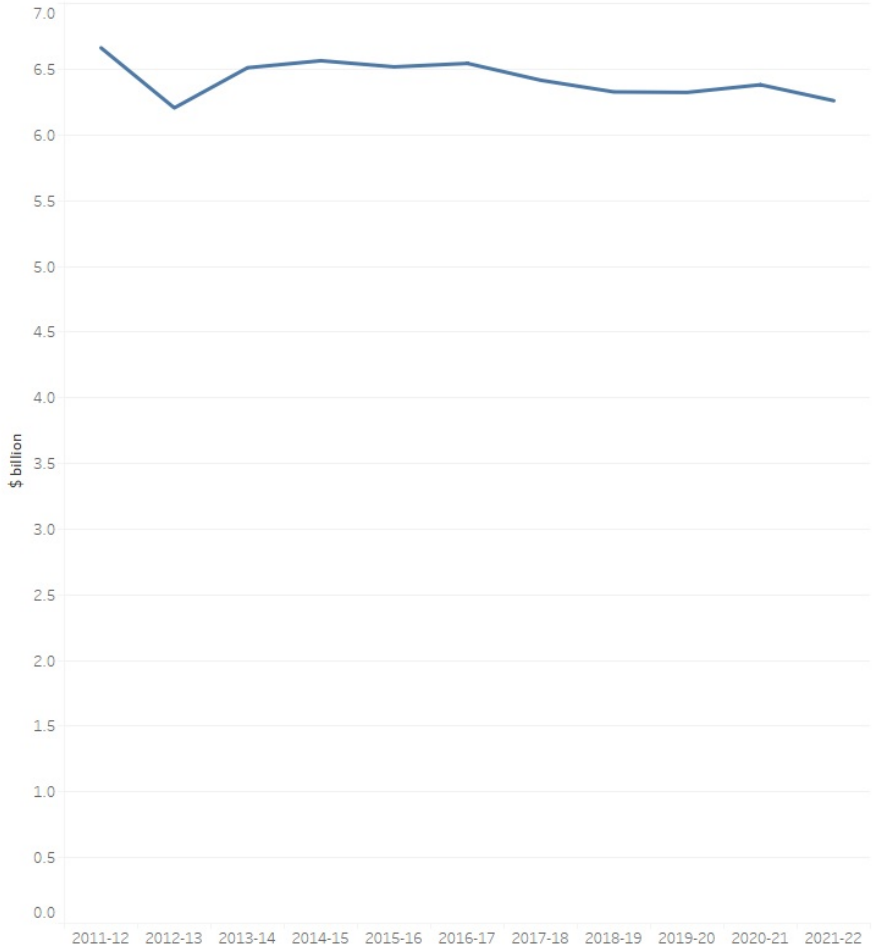
Over the decade since 2011–12, primary health care had the highest average annual growth rate by the Australian Government (4.6% per year), followed by public hospital services (3.8% per year) and referred medical services (3.6% per year) (Figure 11). Note that growth calculations for Australian Government public hospital funding do not include additional components of MBS spending as stated above.

Private health insurance premium rebates

In 2021–22, the rebate for private health insurance premiums paid by the Australian Government was $6.3 billion, a real decrease of $121 million from 2020–21 (Figure 12). The rebate amount presented here is an estimate of the rebate paid out as benefits (to estimate health spending). This is done to exclude spending on non-health related items such as health insurance advertising. It is therefore smaller than the total rebate paid to individuals to reduce premiums, which are reported elsewhere (such as in DoHAC and ATO annual reports). More details on the estimation can be found in the Australian National Health Account: concepts, methodology and data sources.

Figure 12: Health insurance premium rebates as health spending, constant prices [(a)], 2011-12 to 2021-22

The line graph shows that health insurance premium rebates decreased from $6.7 billion in 2011–12 to 6.2 billion in 2012–13 and after that fluctuated around $6.2 billion to $6.5 billion.



[(a)] Constant price health spending is in 2021–22 prices.

Notes:

1. The premium rebate is pro-rated across all expense categories (including change in provisions for outstanding claims). The rebate includes rebates paid through the tax system as well as rebates paid to funds, which directly reduce premiums.
2. Other services include patient transport services, aids and appliances, and administration.

Source: AIHW Health Expenditure Database (Table 14).

Department of Veterans' Affairs spending

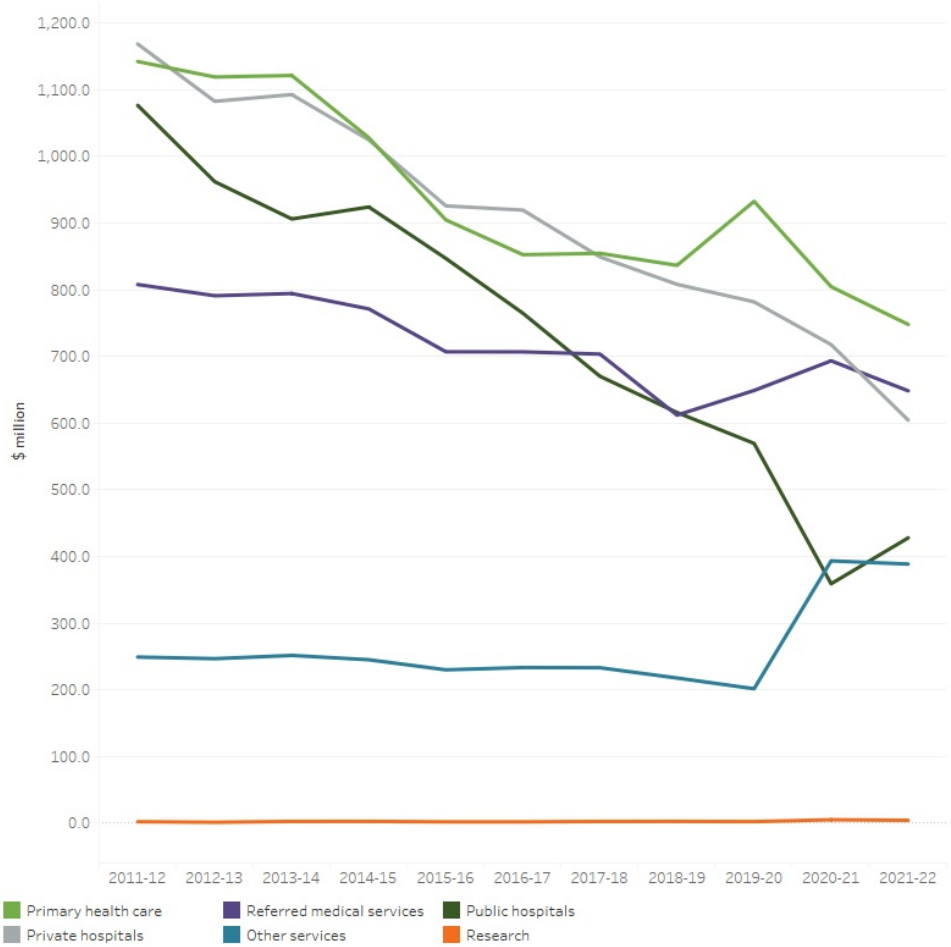
In 2021–22, the DVA spent $2.8 billion on health, mostly on hospitals ($1.0 billion), primary health care ($0.7 billion) and referred medical services ($0.6 billion). Total DVA spending decreased by 5.1% in 2021–22 (Figure 13a). Note that DVA changed their reporting system of health expenditure since 2020–21 which has some impacts on the time series of health spending in this report. Therefore, caution should be exercised when comparing results between years.

DVA spending on hospitals declined over the decade to 2021–22, with public hospitals decreasing by an average of 8.8% per year and private hospitals by 6.4% in real terms. Once again, note that the change of DVA reporting system affected the growth rates over the years. DVA spending on primary health care also decreased in real terms by a yearly average of 4.1%, accompanied by an average decrease in spending on referred medical services by 2.2%. During this period, Other services (including Patient transport services, Aids and appliances, and Administration) increased by 4.5%.

Based on the number of people in the DVA treatment population (which includes all DVA Orange, Gold and White cardholders), DVA spent $10,190 on health per member of the treatment population in 2021–22 which is 8.8% higher than the health spending per person in the total Australian population ($9,365). This average health spending per member of the DVA treatment population peaked in 2014–15 and decreased over the period 2015–16 to 2021–22 (Figure 13b). This recent downward trend in the health spending per member of the DVA treatment population is due to the decline in the number of Veteran Gold Card Holders and increase in those of Veteran White Card Holders. DVA will pay for the hospital treatment costs for Veteran White Card holders for accepted conditions or conditions under non-liability health care whereas all hospital services that meet the clinical needs of Veteran Gold Card holders are paid by DVA.

Figure 13a: Department of Veterans' Affairs health spending by area of spending, constant prices [(a)], 2011-12 to 2021-22

The line graph shows that Department of Veterans' Affairs spent the most on primary health care and least on research. In 2021–22, $427.9 million was spent on public hospitals, $604.5 million on private hospitals, $748 million on primary health care, $648.4 million on referred medical services, and $388.6 million on other services.

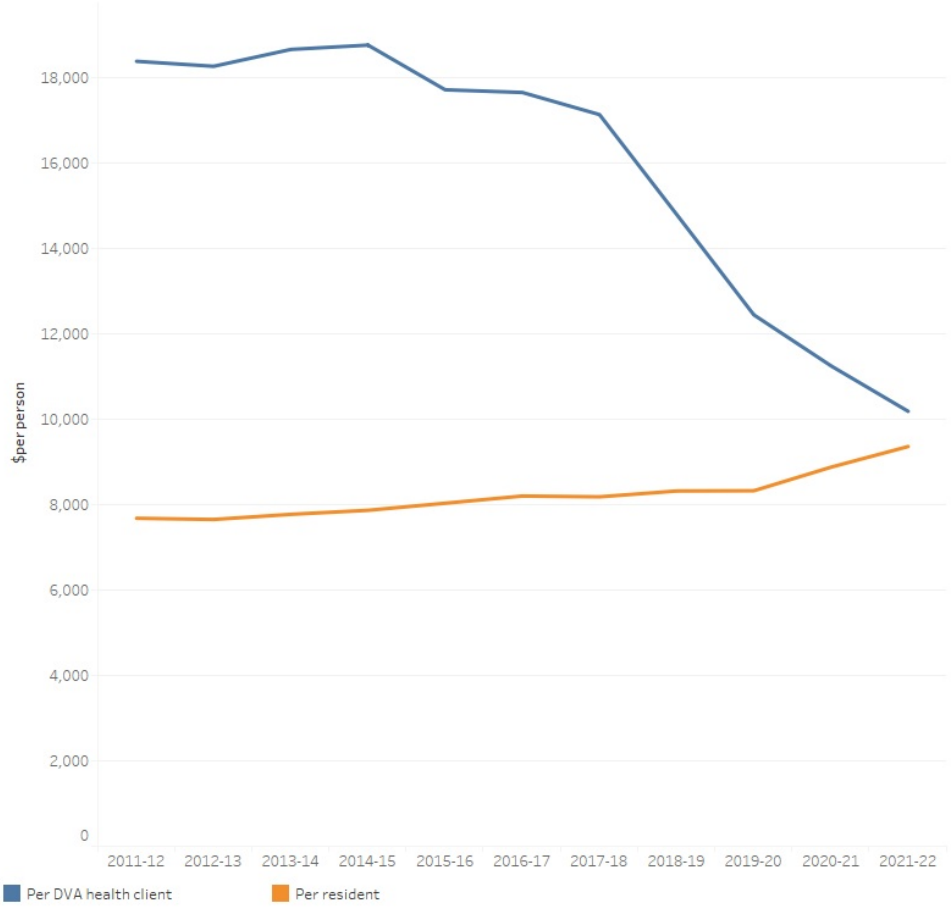


[(a)] Constant price health spending is in 2021–22 prices.

Source: AIHW Health Expenditure Database (Table 15).

Figure 13b: Average health spending per client of the DVA treatment population and per person in the Australian resident population, constant prices [(a)], 2011–12 to 2021–22 ($)

Average health spending per client of DVA treatment population increased from $18,391 in 2011–12 to $18,770 in 2014–15, and then decreased to $10,190 in 2021–22. Health spending per member of DVA treatment population is often higher than the health spending per person in the total Australian population during the 10-year period.



[(a)] Constant price health spending is in 2021–22 prices.

Sources: AIHW Health Expenditure Database; Australian Bureau of Statistics (2023a); Department of Veterans' Affairs (2022) (Table 15)

Department of Defence health spending

In 2021–22, the Department of Defence (Joint Health Command) spent $568 million on heath. This was a decrease of 4.2% ($25.0 million) from 2020–21 in real terms. In 2021–22, the biggest area of spending was other health practitioners ($164 million), followed by referred medical services ($128 million), unreferred medical services ($88 million), private hospitals ($74 million), dental services ($52 million) and administration ($37 million).

The amounts shown represent actual health expenditure by the Department of Defence for its ADF and APS employees that could be categorised as per AIHW's area of expenditure classification, including direct spending on health care to members, direct costs of pharmaceuticals purchased by the Department and costs for administration, including the Defence electronic health record.

Note that it is not possible to reconcile this exactly against other departmental financial reporting because some expenditure within the Joint Health Command is not related to patient care and because of the accounting practices (e.g. cost accrual) employed in departmental reporting. There are also areas of health expenditure within the Department that cannot be extracted from Departmental reporting such as building maintenance and other infrastructure costs and material used within the operational environment.

Spending trends by source

On this page:

State and territory government spending

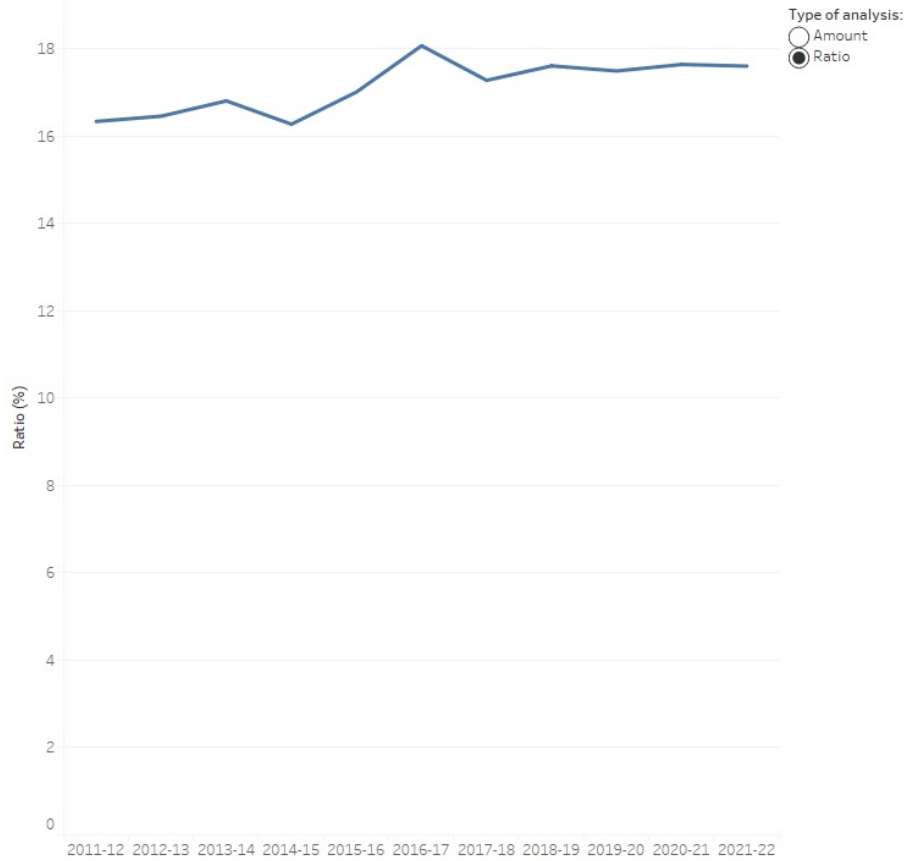
In 2021–22, state and territory governments spent $70.2 billion on health. In real terms, this was an 11.0% growth in spending from 2020–21 – an additional $6.9 billion (Table 10). This real growth rate was higher than the average growth rate over the period from 2011–12 to 2021–22 (4.0% per annum).

Spending relative to government expenses

In 2021–22, the ratio of state and territory government health spending to their total state and territory government expenses was 17.6%, similar to the ratio in 2020–21 (Figure 14) (Table 16).

Figure 14: Ratio of state and territory government health spending to state and territory government expenses, current prices, 2011-12 to 2021-22

The line graph shows the dollar amounts of the state and territory government expenses and health spending with additional line showing the ratios of the state and territory government health spending to government expenses as a percentage. State and territory government health spending increased from $38 billion in 2011–12 to $70.2 billion in 2021–22. Government expenses increased from $232.5 billion in 2011–12 to $398.7 billion in 2021–22. Ratio of health spending to government expenses increased over the 10-year period from 16.3 per cent to 17.6 per cent.



Notes:

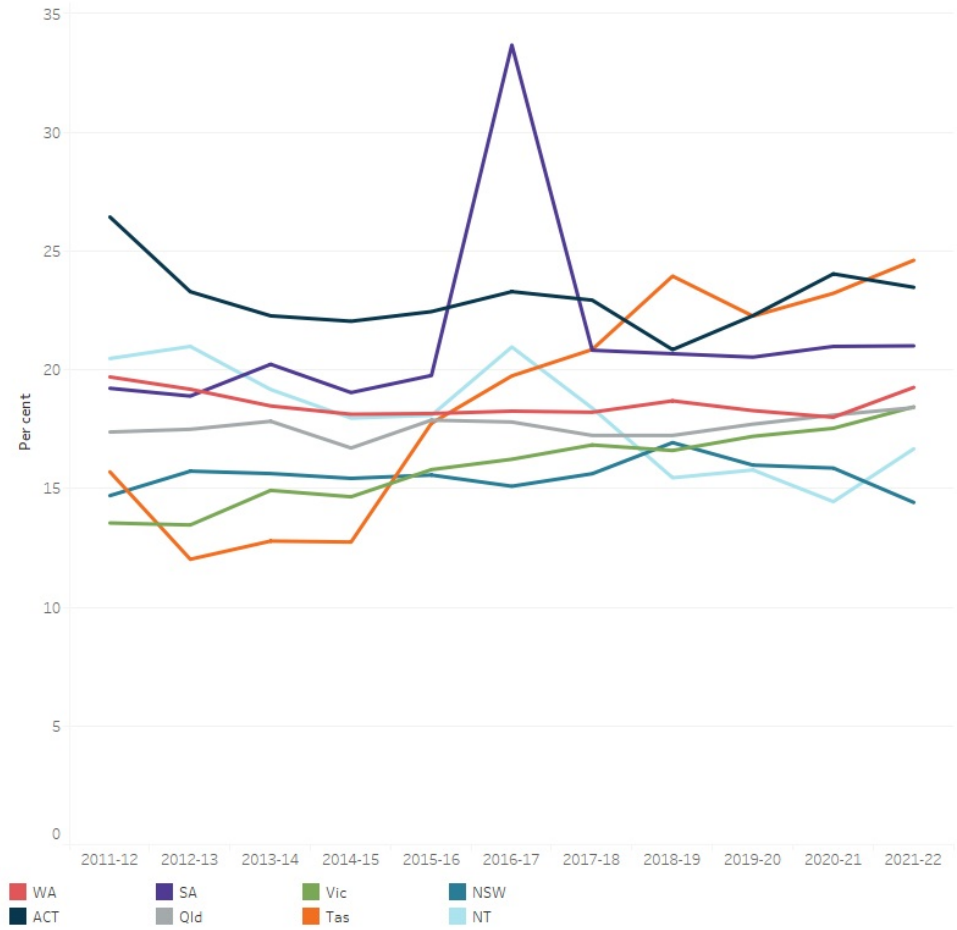
1. State and territory government expenses comprise these government expenses from state and local governments.
2. The ratio increased in 2016–17 due to a large one-off capital spending project in South Australia.
3. For more information about concepts, definitions and data sources, see Overview of data sources and methodology of Health Expenditure Australia 2021–22 report.

Sources: AIHW Health Expenditure Database; Australian Bureau of Statistics (ABS 2023c) (Table 11).

In 2021–22, the ratio of health spending to government expenses differed across state and territories, with the highest in Tasmania (24.6%) and lowest in New South Wales (14.4%) (Figure 15). The ratio increased for Victoria, Queensland, Western Australia, South Australia, Tasmania and the Northern Territory in 2021–22 while declined for the others.

Figure 15: Ratio of total health spending to government expenses for each state and territory government, current prices, 2011-12 to 2021-22

The line graph shows that ratio of health spending to government expenses for all states and territories from 2011–12 to 2021–22. Over the 10-year period, the list of average ratios from highest to lowest is Tasmania (24.6 per cent), Australian Capital Territory (23.5 per cent), South Australia (21.0 per cent), Western Australia (19.3 per cent), Victoria (18.4 per cent), the Queensland (18.4 per cent), the Northern Territory (16.7 per cent) and New South Wales (14.4 per cent). The ratio increased significantly in 2016–17 for South Australia due to a large one-off capital spending project.



Notes:

1. Government expenses include these government expenses from state and local governments.
2. The ratio increased in 2016–17 due to a large one-off capital project in South Australia.

Sources: AIHW Health Expenditure Database; Australian Bureau of Statistics (ABS 2023c) (Table 17).

Area of spending

In 2021–22, state and territory governments spent $43.8 billion (62.5%) on hospitals, with the most ($42.6 billion) on public hospitals. Another $14.7 billion (21.0%) was spent on primary health care; of which community health services and public health were $7.3 billion, $6.5 billion respectively (Figure 16; Table A6).

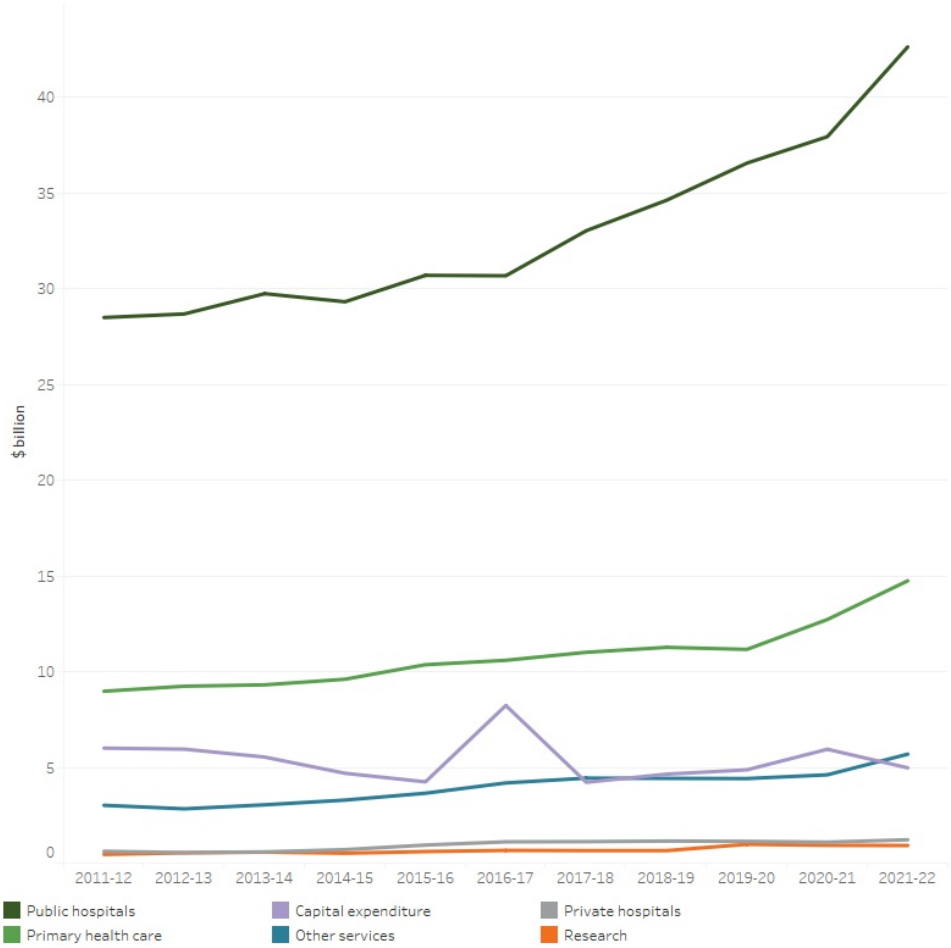
In 2021–22, state and territory spending increased in real terms in these main areas:

- public hospital services by $4.7 billion (12.4% increase compared with 2020–21)
- public health by $2.6 billion (68.1% increase)
- other services (patient transport services, aids and appliances, administration) by $1.1 billion (23.4% increase).

Spending on capital decreased by $1.0 billion (16.3%).

Figure 16: State and territory government total health spending, by area of spending, constant prices [(a)], 2011-12 to 2021-22

The line graph shows that state and territory government health spending increased from 2011–12 to 2021–22 in all areas of spending. For the overall 10-year period, the largest increase was for public hospitals ($28.5 billion in 2011–12 to $42.6 billion in 2021–22), followed by primary health care ($9.0 billion in 2010–12 to $14.7 billion in 2021–22). State and territory government health spending was relatively flatter for private hospitals, other services and research. Capital spending by state and territory government increased in 2016–17 due to a large one-off capital spending project in South Australia.



(a) Constant price health spending is in 2021–22 prices.

Notes

1. There was no state and territory government spending on referred medical services.
2. Primary health care excludes unreferred medical services, benefit-paid pharmaceuticals and all other medications.
3. Other services exclude aids and appliances.
4. State and territory government capital spending increased in 2016–17 due to a one-off capital spending in South Australia.

Source: AIHW Health Expenditure Database (Table 18).

These estimates of public hospital spending differ from those reported in the NHFB statistics for a range of reasons, including where funding is provided to support public hospital service delivery outside the NHFP. More details can be found in Comparison and alignment of Australian health expenditure estimates.

Spending trends by source

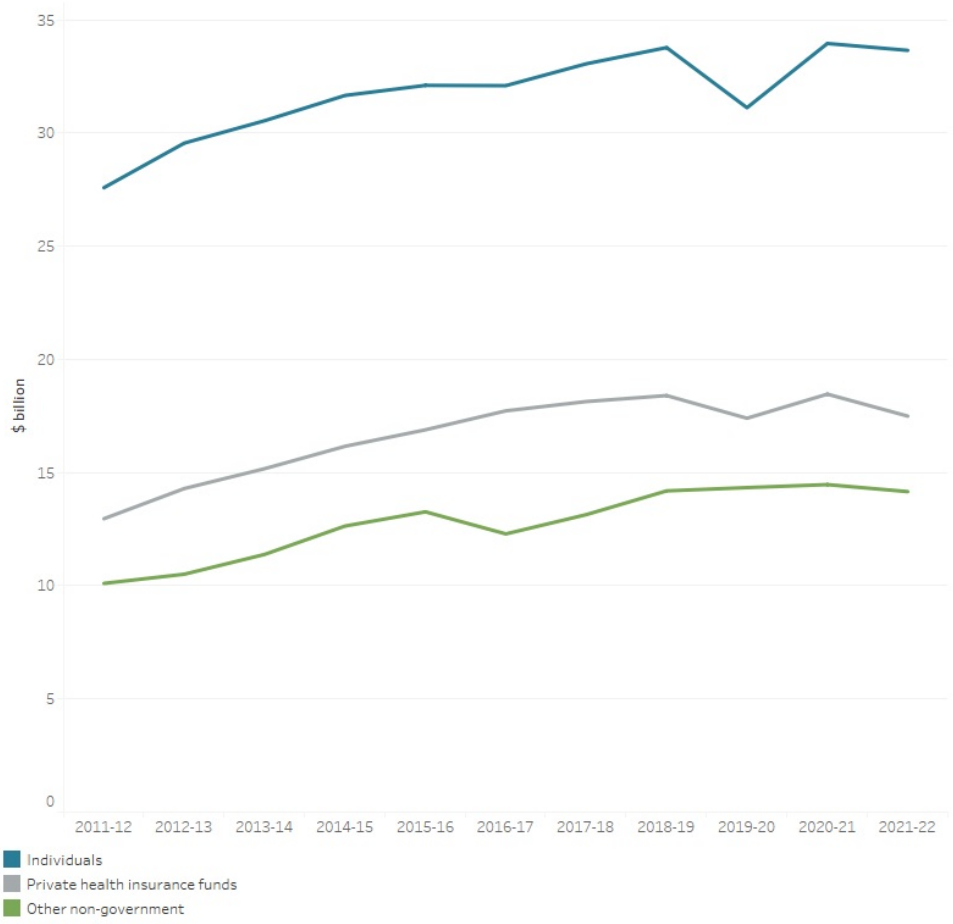
On this page:

In 2021–22, non-government sources spent $65.3 billion on health (Figure 17a), a 2.4% decrease in real terms compared to the previous year. Individuals contributed $33.7 billion, just over half (51.5%) of non-government health spending, private health insurance providers $17.5 billion (26.8%) and other non-government sources $14.2 billion (21.7%).

It is likely that COVID-19 restrictions and temporary suspension of non-urgent elective surgery and non-essential treatments in most states and territories resulted in lowering spending by individuals, private health insurance providers, and other non-government entities in 2021–22. However, note that the actual non-government health spending was below the 10-year historical trend before the pandemic (2008–09 to 2018–19, Figure 17b).

Figure 17a: Non-government health spending, constant prices [(a)], by source of funds, 2011–12 to 2021–22

The line graph shows that spending by individuals increased each year and overall, from $27.6 billion in 2011–12 to $33.7 billion in 2021–22. Spending by private health insurance funds also increased each year and overall from $13.0 billion in 2011–12 to $17.5 billion in 2021–22. Apart from the decrease in 2016–17, over the 10-year period other non-government spending increased overall from $10.1 billion in 2011–12 to $14.2 billion in 2021–22.



[(a)] Constant price health spending is in 2021–22 prices.

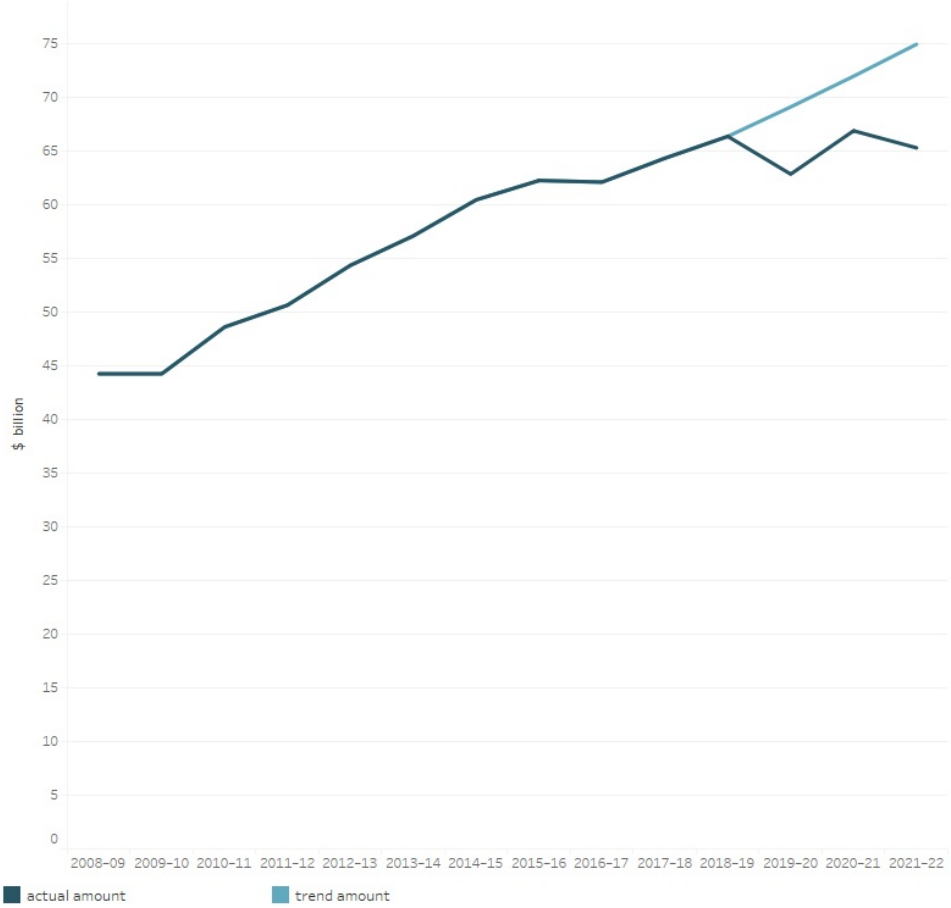
Notes

1. Funding by private health insurance funds excludes the Australian Government private health insurance premium rebate.
2. Other non-government refers to spending on health goods and services by injury compensation insurers and other sources of private income. All non-government sector capital spending is also included here since the funding sources of non-government capital spending are not known. If funding sources were known, this capital spending would be spread across all non-government funding sources.

Source: AIHW Health Expenditure Database (Table 19).

Figure 17b: Non-government health spending, constant prices, during the COVID-19 pandemic (2019–20 to 2021–22) compared with the pre-pandemic period

The line graph shows the total non-government health spending, in the three years during the COVID-19 pandemic (2019–20 to 2021–22) compared to the trend of the previous 10-year period (2008–09 to 2018–19). Assuming the average growth rate for the previous 10-year period remains the same from 2019–20 to 2021–22, the trend amounts of non-government health spending in constant prices from 2019–20 to 2021–22 were $69.1 billion, $72 billion, and $75.0 billion respectively. While the actual amounts for these years were $62.9 billion, $66.9 billion, and $65.3 billion, respectively.



Notes

1. Actual amount is the health spending in 2021–22 prices.
2. Trend amount refers to the heath spending in 2021–22 prices, following the trend of the previous 10-year period (assuming the average annual growth rate for the previous 10-year period remains the same for the period from 2019–20 to 2021–22).
3. Funding by private health insurance funds excludes the Australian Government private health insurance premium rebate.
4. Other non-government refers to spending on health goods and services by injury compensation insurers and other sources of private income. All non-government sector capital spending is also included here since the funding sources of non-government capital spending are not known. If funding sources were known, this capital spending would be spread across all non-government funding sources.

Source: AIHW Health Expenditure Database (Table 19).

Individual spending

Individuals spent an estimate of $33.7 billion out-of-pocket on health goods and services in 2021–22. This was 0.9 percentage points less than in 2020–21 in real terms (Table 20). Once again note that the actual health spending by individuals was still below the 10-year trend before the pandemic (2008–09 to 2018–19, Figure 18b).

In 2021–22, individuals spent an estimate of $11.8 billion (35.1%) on medications not subsidised through the PBS, including over-the-counter medications, vitamins and health-related products. Another $6.7 billion (19.8%) was spent on dental services and $5.0 billion (14.9%) on both referred and unreferred medical services (Table 20).

Individuals' spending on private hospitals decreased by 10.3% compared to 2020–21, most likely due to COVID -19 restrictions on access to private hospitals for non-urgent elective surgery in 2021–22.

Per person individual health spending

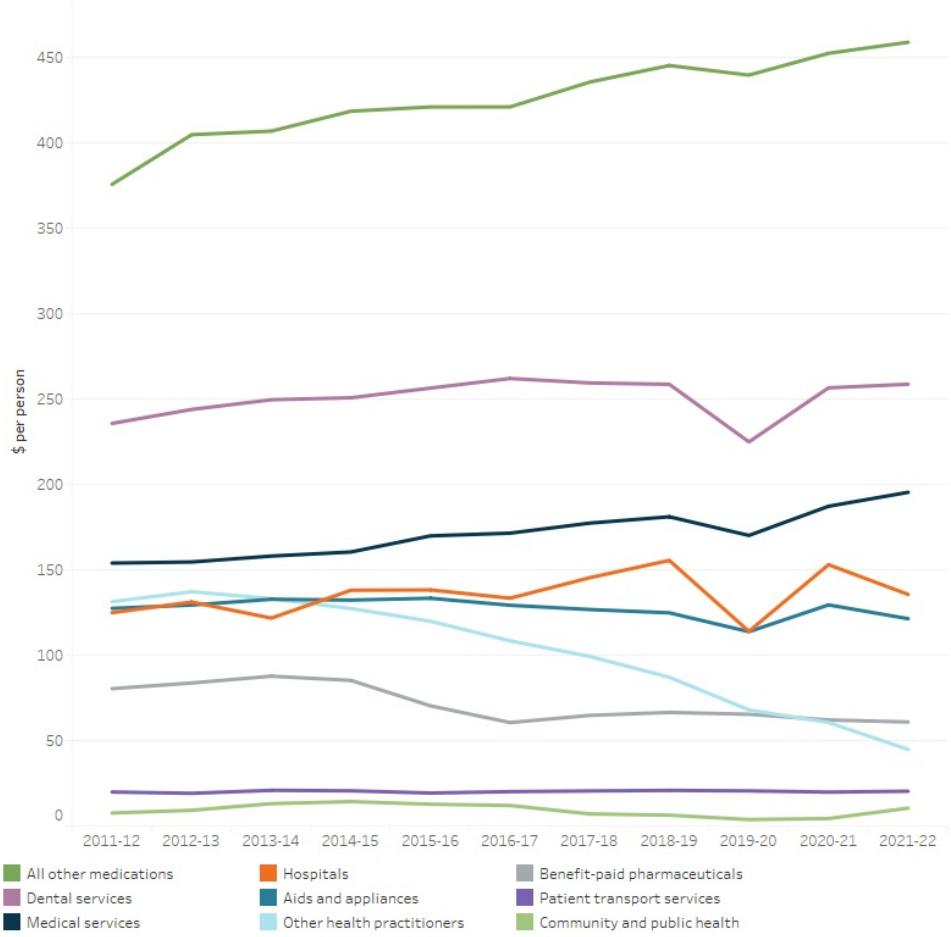
Health spending by individuals equated to an average of $1306 per person in 2021–22.
This was made up of:

- $459 on non-subsidised medications
- $259 on dental services
- $195 on referred and unreferred medical services
- $135 on hospital services
- $121 on aids and appliances
- $61 on medications partly subsidised by the PBS
- $45 on health practitioners, such as chiropractors, optometrists, practice nurses and physiotherapists (Figure 18a).

This annual per person spending decreased by 1.4% in 2021–22 in real terms, $19 less than in 2020–21.

Figure 18a: Average [a] per person individual health expenditure, by area of expenditure, constant prices [b], 2011-12 to 2021-22

The line graph shows per person health spending by individuals for hospitals, patient transport services, medical services, dental services, other health practitioners, community and public health, benefit-paid pharmaceuticals, all other medications and aids and appliances from 2011–12 to 2021–22. In 2021–22, per person health spending increased for all other medications, medical services, dental services, patient transport services, and community and public health while decreasing for other areas of spending as compared to 2020–21. Over the 10-year period, per person health spending by individuals on all other medications increased by a relatively larger amount from $375.5 in 2011–12 to $458.7 in 2021–22. Per person spending by individuals on hospitals steadily increased from $124.8 in 2011–12 to $152.9 in 2020–21 before declining to $135.5 in 2021–22. Per person health spending by individuals on other practitioners increased from $131.2 in 2011–12 to $137.1 in 2012–13, and then decreased to $44.8 in 2021–22.



[a] Based on ABS annual estimated resident population (Table37).

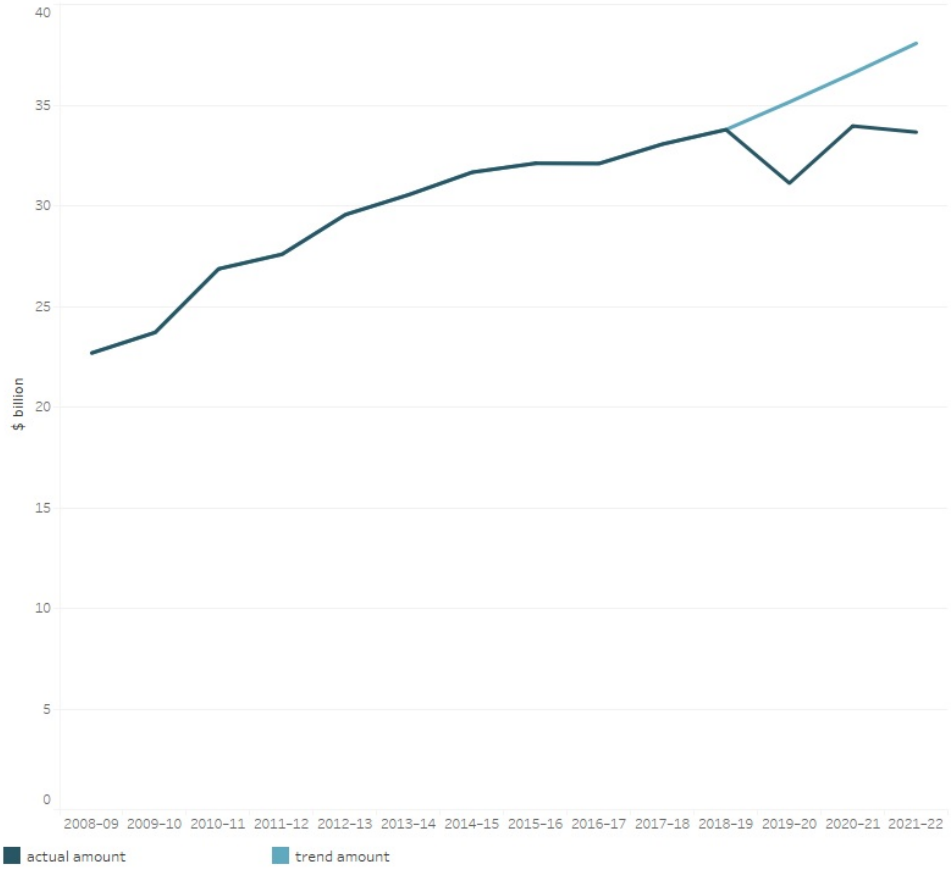
[b] Constant price health spending is in 2021–22 prices.

Note: Medical services refers to both referred and non-referred medical services.

Source: AIHW Health Expenditure Database (Table 21).

Figure 18b: Individuals health spending, constant prices, during the COVID-19 pandemic (2019-20 to 2021-22) compared with the pre-pandemic period

The line graph shows the total individual health spending, in the three years during the COVID-19 pandemic (2019–20 to 2021–22) compared to the trend of the previous 10-year period (2008–09 to 2018–19). Assuming the average growth rate for the previous 10-year period remains the same from 2019–20 to 2021–22, the trend amounts of individuals health spending in constant prices for 2019–20, 2020–21, and 2021–22 were $35.2 billion, $36.6 billion, and $38.1 billion respectively. While the actual amounts for these years were $31.1 billion, $34.0 billion, and $33.7 billion, respectively.



Notes:

1. Actual amount is the health spending in 2021–22 prices.
2. Trend amount refers to the heath spending in 2021–22 prices, following the trend of the previous 10-year period (assuming the average annual growth rate for the previous 10-year period remains the same for the period from 2019–20 to 2021–22).

Source: AIHW Health Expenditure Database (Table 20).

Private health insurance provider spending

During 2021–22, providers of private health insurance financed $17.5 billion (7.3%) of total health spending. More than half ($9.7 billion) was for hospital services, with private hospitals receiving an estimated $8.9 billion. Approximately $3.1 billion was spent on primary health care services (Figure 19).

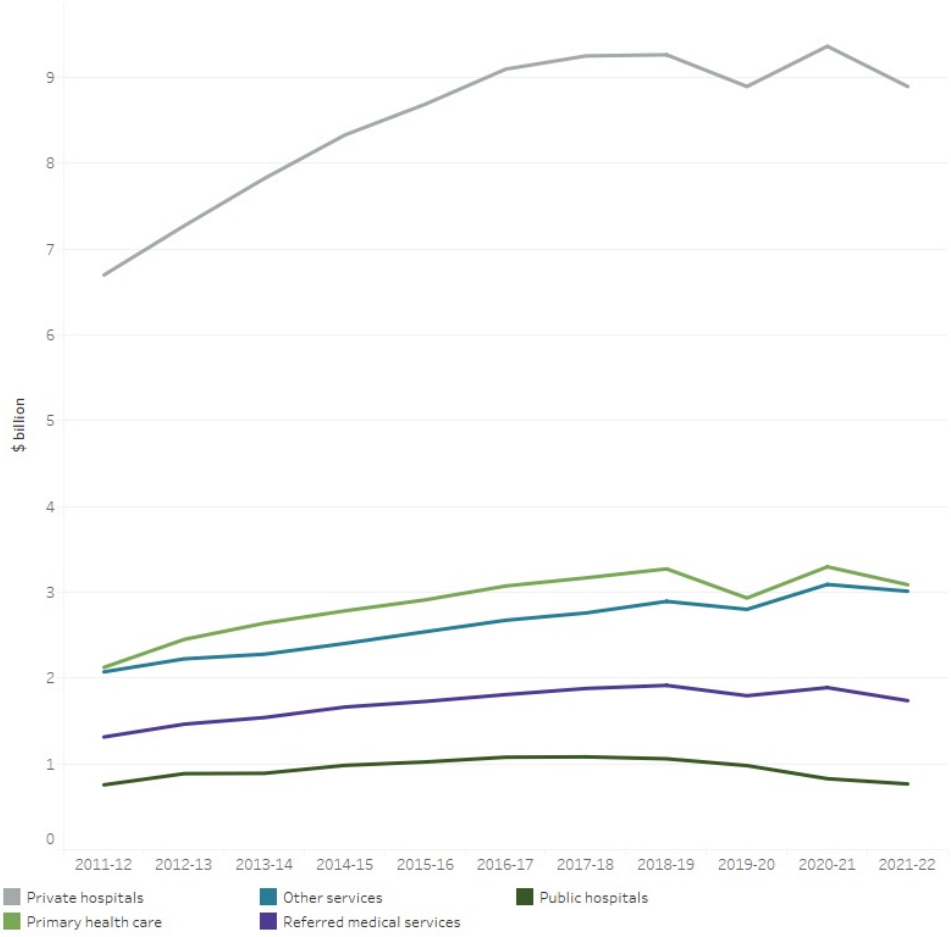
Spending by the private health insurance providers decreased by 5.3% ($1.0 billion) in 2021–22 in real terms, most likely due to COVID-19 restrictions on access to non-urgent elective surgery and non-essential treatments (dental, optical and other health services) (ACCC, 2022). The average annual growth rate for the decade from 2011–12 was 3.0%.

Note that the private health insurance spending on referred medical services are related to the gap payment for in-hospital MBS services which currently could not be split into public and private hospitals due to data unavailability.

Figure 19: Private health insurance provider health spending by area of spending, constant prices [(a)], 2011-12 to 2021-22

The line graph shows private health insurance provider health spending for public hospitals, private hospitals, primary health care, referred medical services and other services from 2011–12 to 2021–22. During 2020–21 to 2021–22, there was an overall decrease in private health insurance provider health spending for most areas of spending. In 2021–22, private health insurance provider health spending on private

hospitals, primary health care, other services, referred medical services and public hospitals were $8.9 billion, $3.1 billion, $3.0 billion, $1.7 billion and $0.8 billion respectively.



[a] Constant price health spending is in 2021–22 prices.

Notes:

1. This shows the payments made by health insurance funds over the year and does not necessarily reflect the actual services provided during the year.
2. Other services include patient transport services, aids and appliances, and administration.

Source: AIHW Health Expenditure Database (Table 22).

Private health insurance provider health spending per person covered

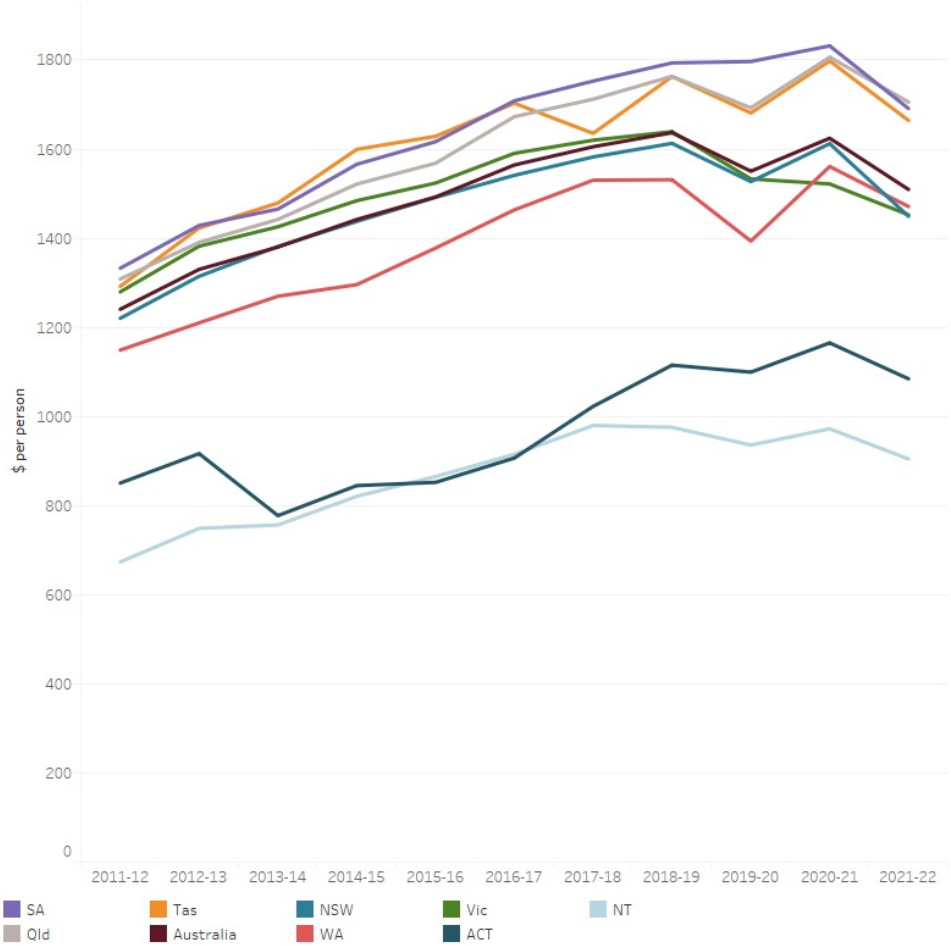
In 2021–22, private health insurance providers spent an estimated average of $1,509 per person covered by a private hospital insurance policy. This was a decrease of $115 (7.1%) from 2020–21 in real terms. The average annual growth for the decade to 2021–22 was 2.0% (Figure 20).

Queensland ($1,705), South Australia ($1,691), and Tasmania ($1,664) had the highest spending by private health insurers per person covered, at more than 1.8 times the amount of the Northern Territory ($905) (Figure 20).

Nationally, spending by private health insurers equated to an average of $679 per person in 2021–22, including those not covered by private health insurance. This represented a decrease of 5.8% from 2020–21 in real terms. The average annual growth rate for the decade from 2011–12 was 1.7% (Table 24).

Figure 20: Average per person [a] spending by private health insurance providers for each state and territory, constant prices [b], 2011–12 to 2021–22

The line graph shows that average per person spending by private health insurance providers for all states and territories and Australia from 2011–12 to 2021–22. Between 2020–21 to 2021–22, average per person spending for all state and territories and Australia as the whole nation decreased steadily. In 2021–22, average per person spending by private health insurance providers in New South Wales, Victoria, Queensland, Western Australia, South Australia, Tasmania and Australia as the whole nation was around $1,509. At the same time, average per person spending by private health insurance providers was $1,084 for the Australian Capital Territory and $905 for the Northern territory.



(a) Based on the number of people with private hospital insurance cover living in each state and territory.

(b Constant price health spending is in 2021–22 prices.

Sources: AIHW Health Expenditure Database; Australian Prudential Regulation Authority (2023a, 2023b) (Table 23).

Other non-government spending

In 2021–22, other non-government sources spent $14.2 billion on health, representing 5.9% of total health spending in the year (Table 10). This showed a decrease of 2.1% compared with 2020–21. The average annual growth rate over the decade to 2021–22 was 3.4%.

During 2021–22, injury compensation insurers spent $3.7 billion on health goods and services: $2.5 billion by workers' compensation insurers and $1.2 billion by compulsory third-party motor vehicle insurers (Table 25).

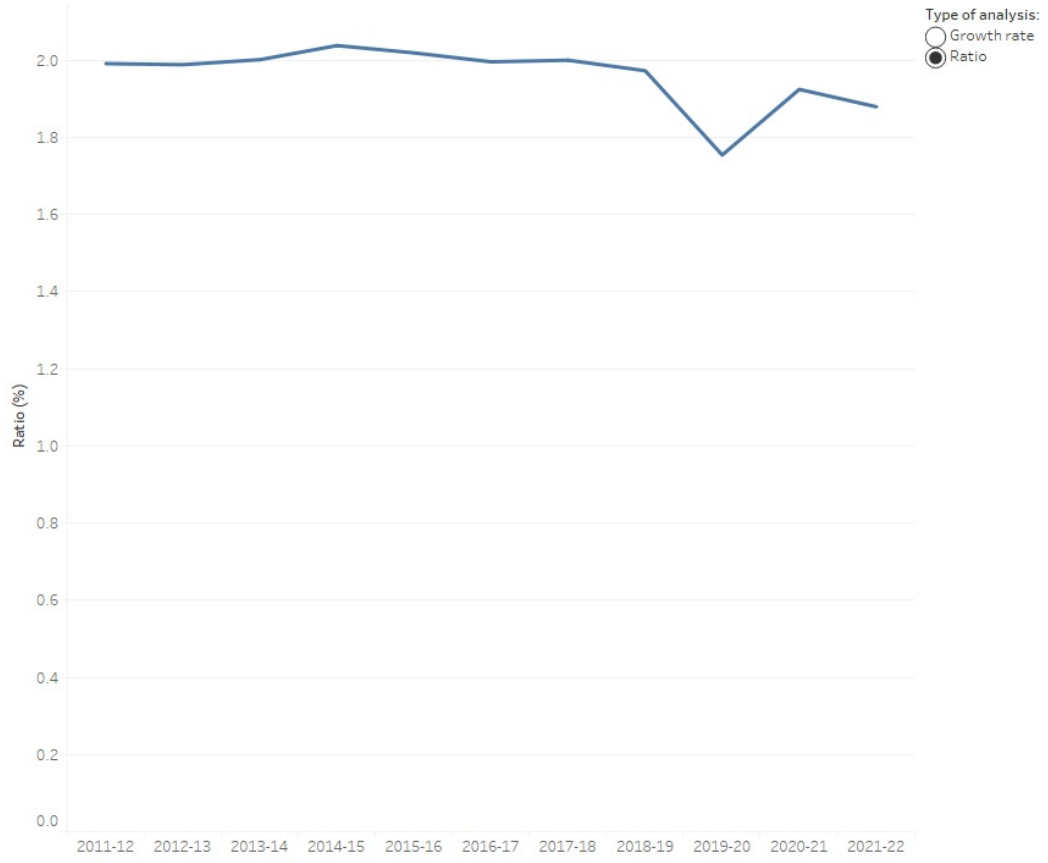
Individuals' health spending relative to income and wealth

To better understand how health spending is impacting the disposable or readily accessible wealth of people (the 'out-of-pocket costs'), health spending by individuals is compared with both average incomes and measures of net worth to understand whether, on average across the population, individuals' health spending is rising relative to personal wealth over time. Note that these are average figures, so the analysis here does not take into account inequality issues in income, wealth, and individuals' health spending.

In 2021–22, health spending by individuals amounted to an average of $1,306 per person, 1.88% of average annual income, a slight decrease from 2020–21 (1.92%) (Figure 21). On average over the decade, individual health spending increased by 2.1% per year compared to 2.7% per year for the average annual income (in current prices).

Figure 21: Ratio of average individual health spending (a) to average annual income (b), current prices, 2011-12 to 2021-22

The line graph shows that annual growth rate in average individual health spending was positive for all years between 2011–12 and 2021–22 except in 2019–20. In the 10- year period, annual growth rate in average individual health spending ranged from –7.5 per cent to 10.7 per cent. Growth rates in average annual income was positive each year in the 10- year period and ranged between 1.0 per cent and 6.7 per cent. The ratio between average individual health spending per person and average annual income was relatively flat with an average of 2.0 per cent.



(a) Based on annual estimated resident population (Table 37).

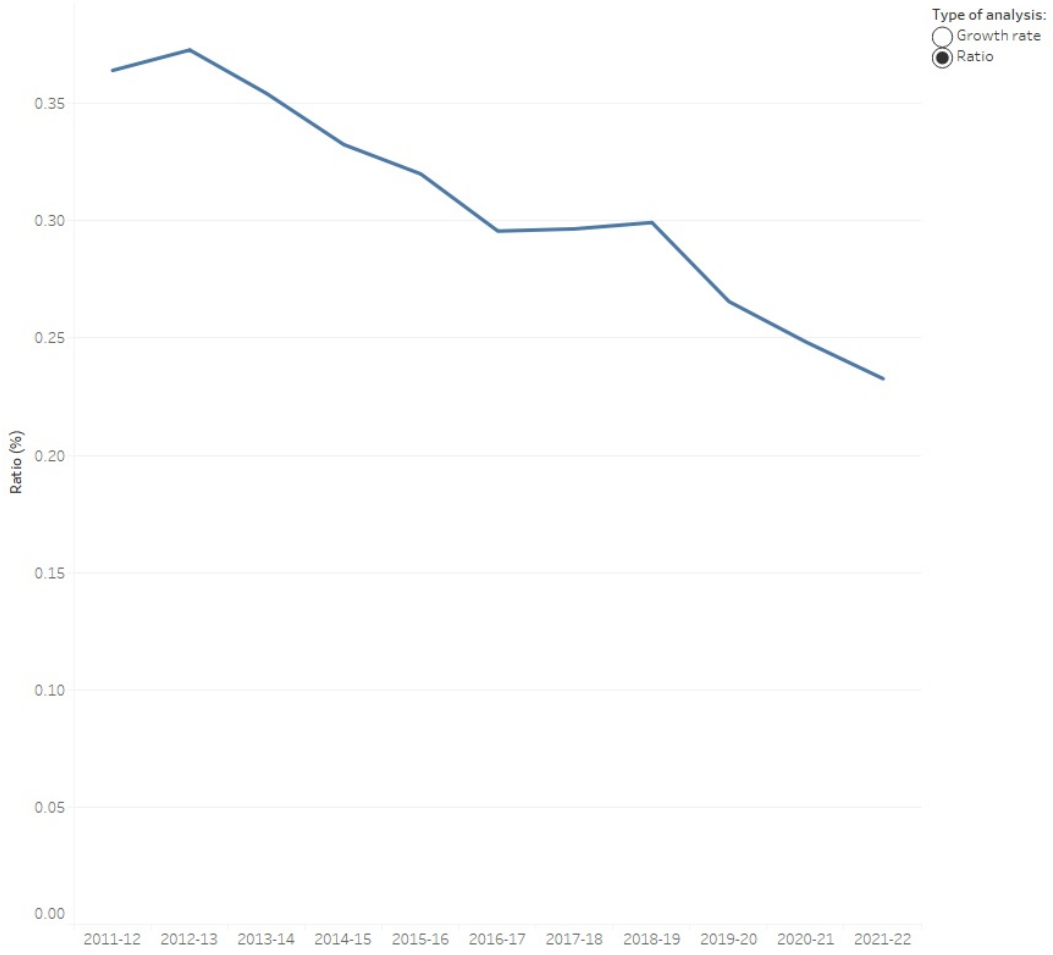
(b) Refers to annualised average weekly earnings.

Sources: AIHW Health Expenditure Database; Australian Bureau of Statistics (2022a, 2023a) (Table 26).

In 2021–22, health spending by individuals represented on average 0.23% of individual net worth, a slight decrease from 2020–21 (0.25%) (Figure 22). In 2021–22, per person net worth grew by 7.7%, while average individual health spending increased by 1.0% in nominal terms. On average over the decade, per person net worth grew nominally by 6.8% per year, while average individual health spending grew by 2.1% per year.

Figure 22: Ratio of average individual health spending (a) to per person net worth (b), current prices, 2011-12 to 2021-22

The line graph shows that both the growth rates in individual net worth and average individual health spending fluctuated between 2011–12 and 2021–22. Annual growth rate in individual net worth was lowest at 0.4 per cent in 2018–19 before reaching its maximum rate at 18.4 per cent in 2020–21. Meanwhile, annual growth rate in average individual health spending was lowest in 2019–20 at –7.5 per cent and highest in 2020–21 at 10.7 per cent. The ratio between per person health spending by individuals and individual net worth was relatively flat with an average of 0.3 per cent.



(a) Based on annual estimated resident population (Table 37).

(b) Refers to annualised net worth.

Sources: AIHW Health Expenditure Database; Australian Bureau of Statistics (2022a, 2023b) (Table 27).

About measures of individual income and wealth

To estimate how individuals' health spending has compared with the financial resources available to individuals, 2 measures are considered:

- income is used to provide a sense of how health spending compared with average earnings throughout the year—how much was spent on health compared with how much earnt in that year
- net worth is used to provide a sense of how health spending compared with the overall wealth position of individuals in a given year, providing a more long-term sense of how health spending compared with personal wealth, particularly where health costs may be too high to be met by regular income.

Trends by area of spending

In 2021–22, total health spending was distributed across health services, with estimates of:

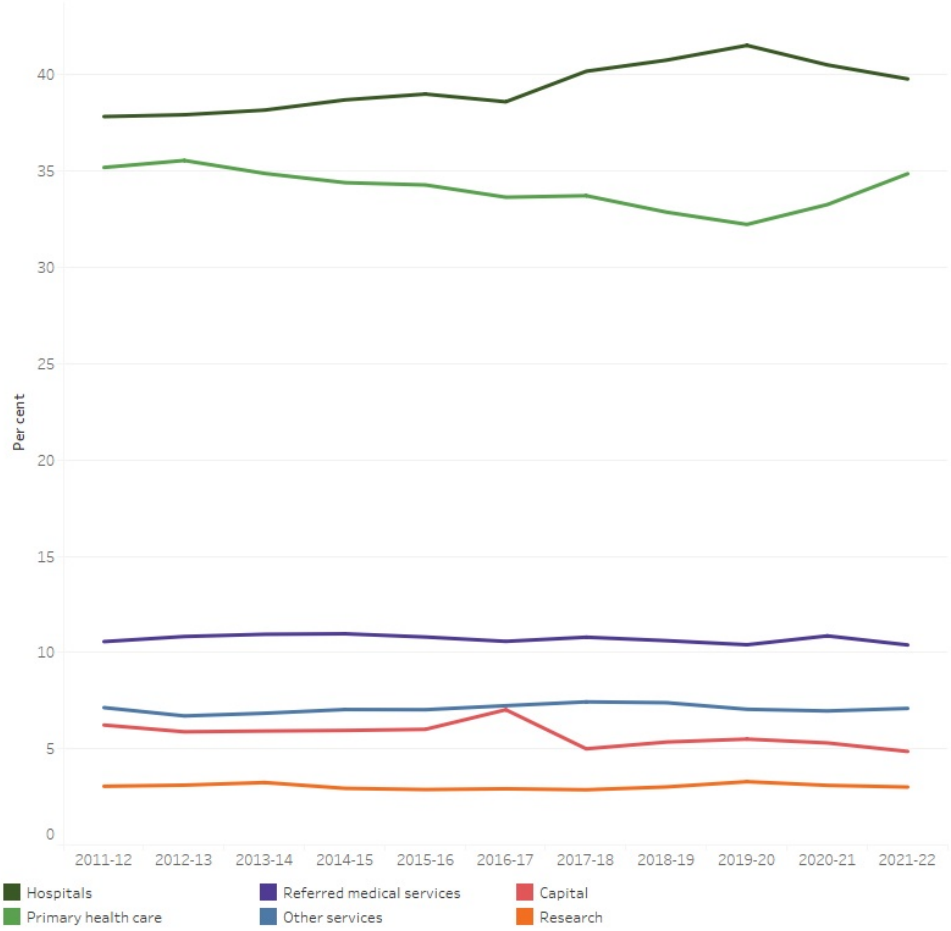
- 39.8% ($96.0 billion) on hospitals
- 34.9% ($84.1 billion) on primary health care
- 10.4% ($25.1 billion) on referred medical services

The remaining 15.0% or $36.1 billion, was on other services, research and capital spending (Figure 23).

Over the period up to 2018–19, spending on hospitals has tended to increase faster than spending on primary health care (3.3% on average per year compared with 2.3%, in real terms). However, this appeared to shift during the pandemic (2019–20 to 2021–22), when spending on primary health care (including public health) increased in real terms by 6.8% on average per year, more quickly than spending on hospital services at an average annual growth of 4.2%.

Figure 23: Proportion of total health spending, by area of expenditure, current prices, 2011–12 to 2021–22

The line graph shows that the proportion of total health spending spent on each area of spending remained relatively stable between 2011–12 and 2021–22. Hospitals and primary health care attracted the most funding over the decade. In 2021–22, hospitals received 39.8 per cent of total health spending, followed by primary health care received 34.9 per cent. In the same year, referred medical services attracted 10.4 per cent of total funding; other services received 7.0 per cent, and research receiving 3.0 per cent. The proportion of funds allocated to capital spending over the decade was most volatile, at 7 per cent in 2016–17 compared with 4.9 per cent in 2021–22.



Notes

1. Spending on the medical expenses tax rebate is not included.
2. Other services include patient transport services, aids and appliances, and administration.

Source: AIHW Health Expenditure Database (Table 28).

Trends by area of spending

On this page:

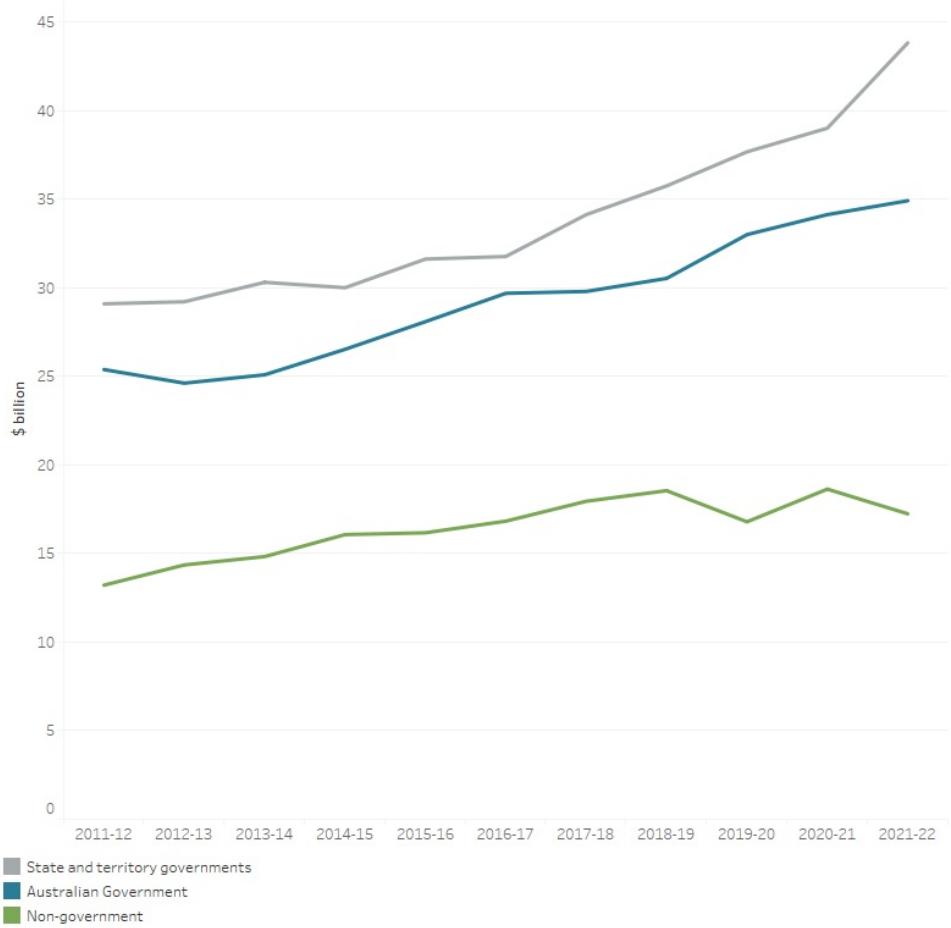
During 2021–22, an estimate of $96.0 billion was spent on Australia's public and private hospitals, with $43.8 billion (45.7%) funded by state and territory governments and $34.9 billion (36.4%) by the Australian Government. The remaining $17.2 billion (18.0%) came from non-government sources (Figure 24).

As outlined in section Australian Government spending section these estimates of Australian Government spending do not include some spending by the Australian Government through the MBS on services delivered in hospitals (up to $4.1 billion, including estimated $1.6 billion in public hospitals and $2.5 billion in private hospitals) see the MBS in public hospitals and Australian National Health Account: concepts, methodology and data sources for more detail.

Spending on hospitals in 2021–22 was 4.6% higher than in 2020–21 and above the average annual growth for the decade (3.6%). The increase in 2021–22 resulted from increased funding by states and territories (12.3%), and the Australian Government (2.3%) in real terms. This increase in hospital spending was accompanied by an increase in hospitalisations involving a COVID-19 diagnosis in 2021–22 though the number of admitted patient care services and emergency department presentations decreased by 2.1% and 0.2% respectively compared to 2020–21 (AIHW 2023a, 2023b). Note that growth calculations for Australian Government public hospital funding do not include additional components of MBS spending as stated above.

Figure 24: Spending on hospitals, by source of funds, constant prices [(a)], 2011–12 to 2021–22

The line graph shows that spending on hospitals increased between 2011–12 and 2021–22 for the Australian Government, state and territory government and non-government sector. State and territory governments had the highest spending on hospitals in every year over the decade. State and territory government spending increased from $29.1 billion in 2011–12 to $43.8 billion in 2021–22. Spending by the Australian Government on hospitals slightly decreased from $25.4 billion in 2011–12 to $24.6 in 2012–13 but then increased every year to $34.9 billion in 2021–22. Non-government spending increased most of the years over the decade, from $13.2 billion in 2011–12 to $18.6 billion in 2018–19, then decreased to $16.8 billion in 2019–20 before bounced back to $18.6 billion in 2020–21 and after that decreased to 17.2 billion in 2021–22.



[a] Constant price health spending is in 2021–22 prices.

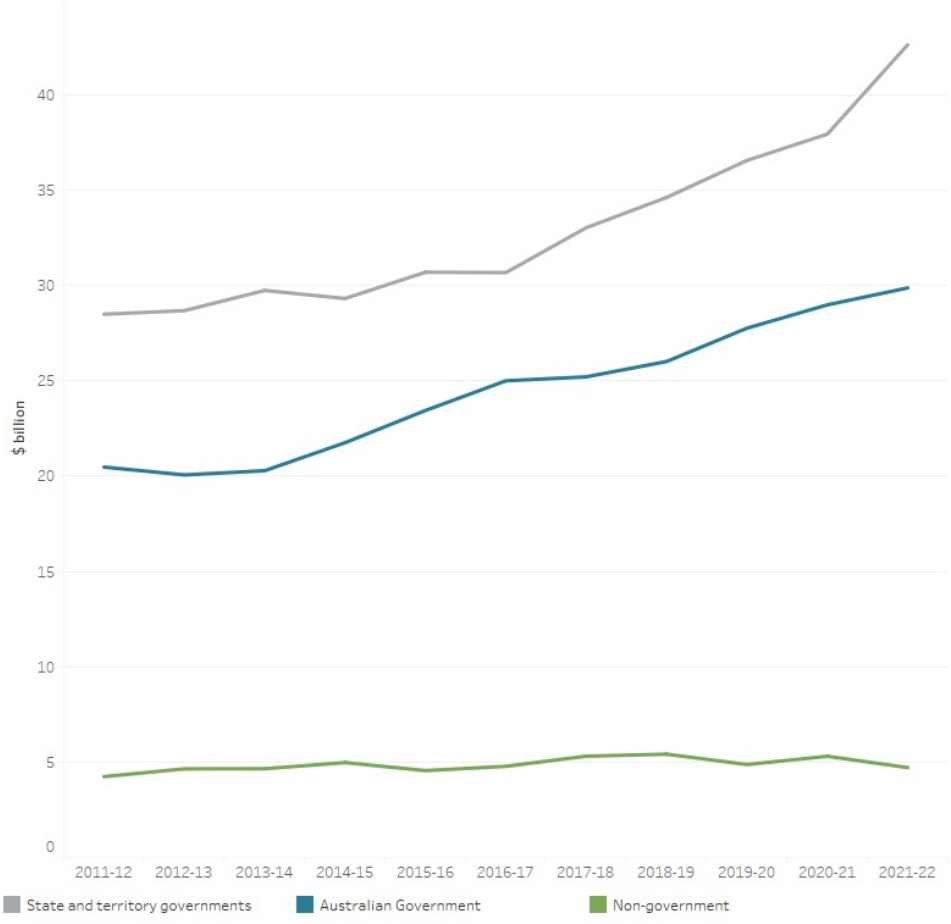
Source: AIHW Health Expenditure Database (Table 29).

Public hospitals

Spending on public hospitals was estimated to be $77.2 billion (Figure 25, note that this figure does not include the $1.6 billion in MBS figures, as mentioned in the MBS in public hospitals). Spending was up from $72.2 billion in 2020–21, a real increase of 6.9%, which was above the average annual real growth over the decade (3.8%).

Figure 25: Public hospital spending, by source of funds, constant prices [a], 2011-12 to 2021-22

The line graph shows that spending on public hospitals by the Australian Government, state and territory governments and non-government sector over the decade from 2011–12 to 2021–22. State and territory governments spent the most on public hospitals of all sources over the decade, increased every year to $42.6 billion in 2021–22. Similarly, Australian Government spending on public hospitals decreased slightly in 2012–13, then increasing every other year to $29.9 billion in 2021–22. Non-government spending on public hospitals fluctuated around $4.2 billion to $5.4 billion over the decade between 2011–12 and 2021–22.



[a] Constant price health spending is in 2021–22 prices.

Note: Public hospital services exclude certain services provided in hospitals, and can include services provided off site, such as hospital in the homes and dialysis.

Source: AIHW Health Expenditure Database (Table 30).

In 2021–22, state and territory governments contributed $42.6 billion (55.2%). This was followed by the Australian Government with between $29.9 billion (as currently estimated, or 38.7%) and $31.5 billion (40.0% if the MBS components are included) and non-government entities at $4.7 billion (6.1%). Growth in spending by the Australian Government was 3.1% in real terms, compared with 12.4% by state and territory governments while non-government entities decreased by 11.2% (Table 30). See more details on the Australian Government spending on public hospital services in MBS in public hospitals box and Table A11.

Over the 10-year period to 2021–22, overall spending increased in real terms by 3.8% on average per year, with the highest increase from state and territory governments (4.1%) and the Australian Government (3.8%), followed by the non-government sector (1.1%) (Table 30).

See Australian National Health Account: Overview of data sources and methodology for more information on data sources and methodologies, as well as a comparison and alignment between this report and other health spending figures published elsewhere, especially related to public hospitals spending.

Private hospitals

Most (66.6%, $12.5 billion) of the estimated $18.8 billion spent on private hospitals was funded by the non-government sector:

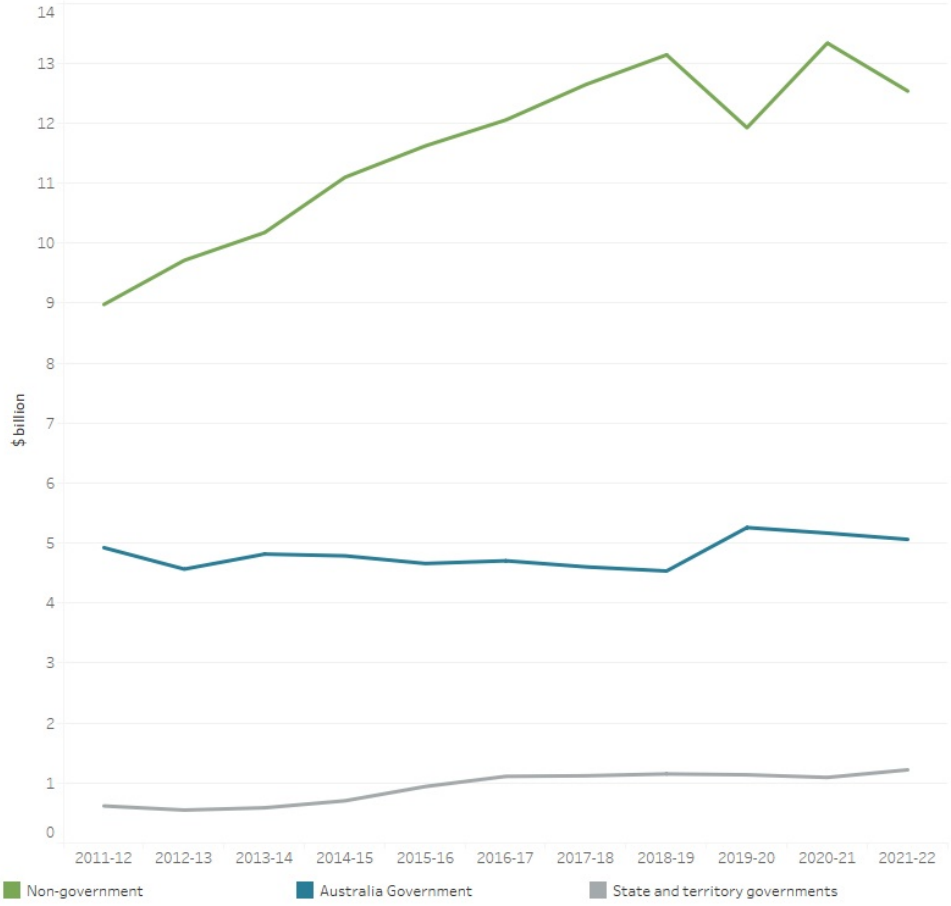
- private health insurance providers, $8.9 billion
- individuals, $2.2 billion
- other non-government, $1.4 billion (Table A6).

Another estimated $5.1 billion (26.9%) was spent by the Australian Government (note that this estimate does not include the MBS components) and $1.2 billion (6.5%) by state and territory governments (Figure 26). Government spending in private hospitals can occur where state and territory governments contract with private hospitals to provide services to public patients, or where individual public hospitals buy services from private hospitals for public patients.

From 2020–21 to 2021–22, non-government spending on private hospitals decreased by $0.8 billion (6.0%) in real terms. Spending on private hospitals funded by the Australian Government declined in real terms by $0.1 billion (2.0%). During the same time, the number of admissions in private hospitals declined by 2.3% after increasing by 10.5% in 2020–21(AIHW 2023a).

Figure 26: Private hospital spending, by source of funds, constant prices [(a)], 2011-12 to 2021-22

The line graph shows that spending on private hospitals by the Australian Government, state and territory governments and non-government sector over the decade from 2011–12 to 2021–22. Non-government sector spent the most on private hospitals of all sources over the decade, increasing from $9.0 billion in 2010–11 to $13.1 billion in 2018–19 then fluctuated from 11.9 billion to 13.3 billion between 2019–20 and 2021–22. Australian Government spending on private hospitals fluctuated from $4.9 billion in 2011–12 to $5.1 billion in 2021–22. State and territory government spending on private hospitals increased from $0.6 billion in 2011–12 to $1.2 billion in 2021–22.



[(a)] Constant price health spending is in 2021–22 prices.

Source: AIHW Health Expenditure Database (Table 31).

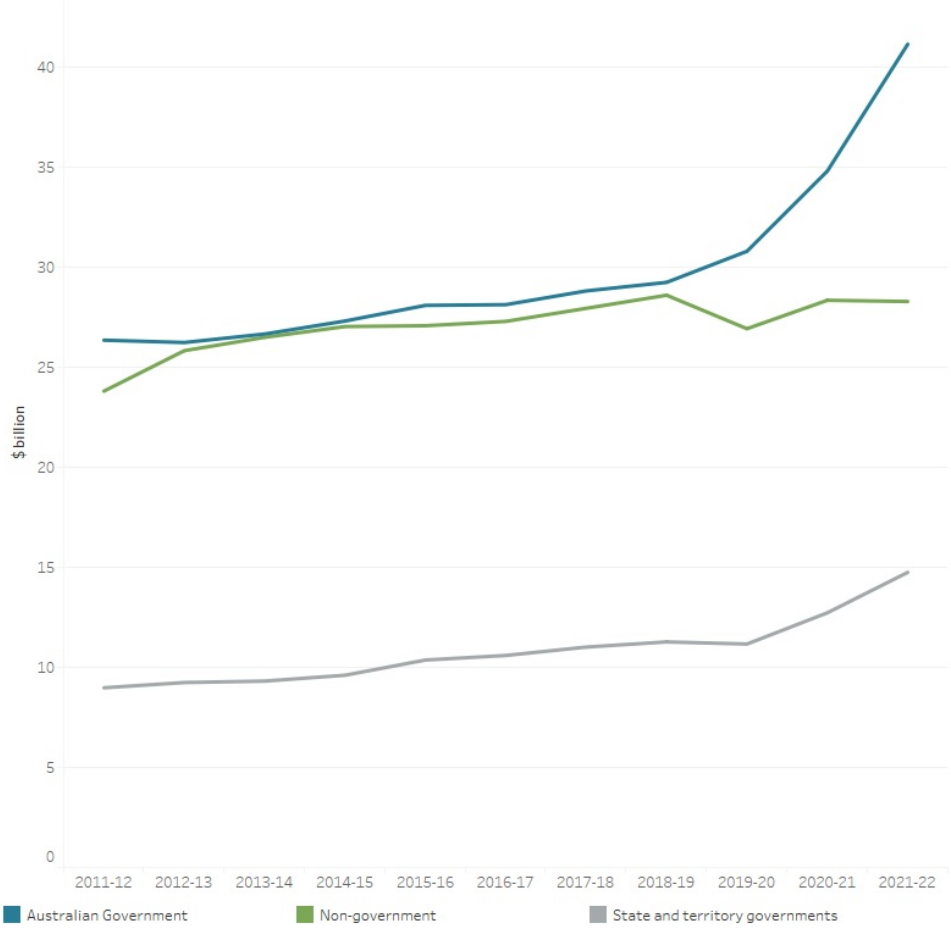
Trends by area of spending

In 2021–22, $84.1 billion was spent on primary health care. Of this, the Australian Government spent $41.1 billion (48.9%), non-government entities $28.3 billion (33.6%), and state and territory governments $14.7 billion (17.5%) (Figure 27).

This represented $8.3 billion increase (10.9%) in spending from 2020–21 in real terms. This growth in 2021–22 was mainly due to increased spending by the Australian Government of $6.3 billion (18.2%) and state and territory governments of $2.0 billion (15.9%) (Table 32).

Figure 27: Primary health care expenditure, by source of funds, constant prices [(a)], 2011-12 to 2021-22

The line graph shows that spending on primary health care by the Australian Government, state and territory governments and non-government sector over the decade from 2011–12 to 2021–22. Australian Government spending on primary health care was the highest of all sources, increasing in most years and reached $41.1 billion in 2021–22. Similarly, state and territory government spending on primary health care also increased over decade from $9.0 billion in 2011–12 to $14.7 billion in 2021–22. Non-government spending increased every year to $28.6 billion in 2018–19, then declined to $26.9 billion in 2019–20 before it bounced back to $28.3 billion in 2021–22.



[(a)] Constant price health spending is in 2021–22 prices.

Note: State and territory governments do not spend on unreferred medical services, benefit-paid pharmaceuticals and all other medications.

Source: AIHW Health Expenditure Database (Table 32).

The increase in spending in real terms on primary health care in 2021–22 was attributable to increases on: public health (increased by $7.6 billion, including spending on COVID-19 vaccines, rapid antigen test kits and personal protective equipment products), community health and other (by $1.1 billion, including psychosocial program support), all other medications (by $0.2 billion), and unreferred medical services (by $0.1 billion, including spending on COVID-19 vaccine suitability assessment services) (tables A5 and A6).

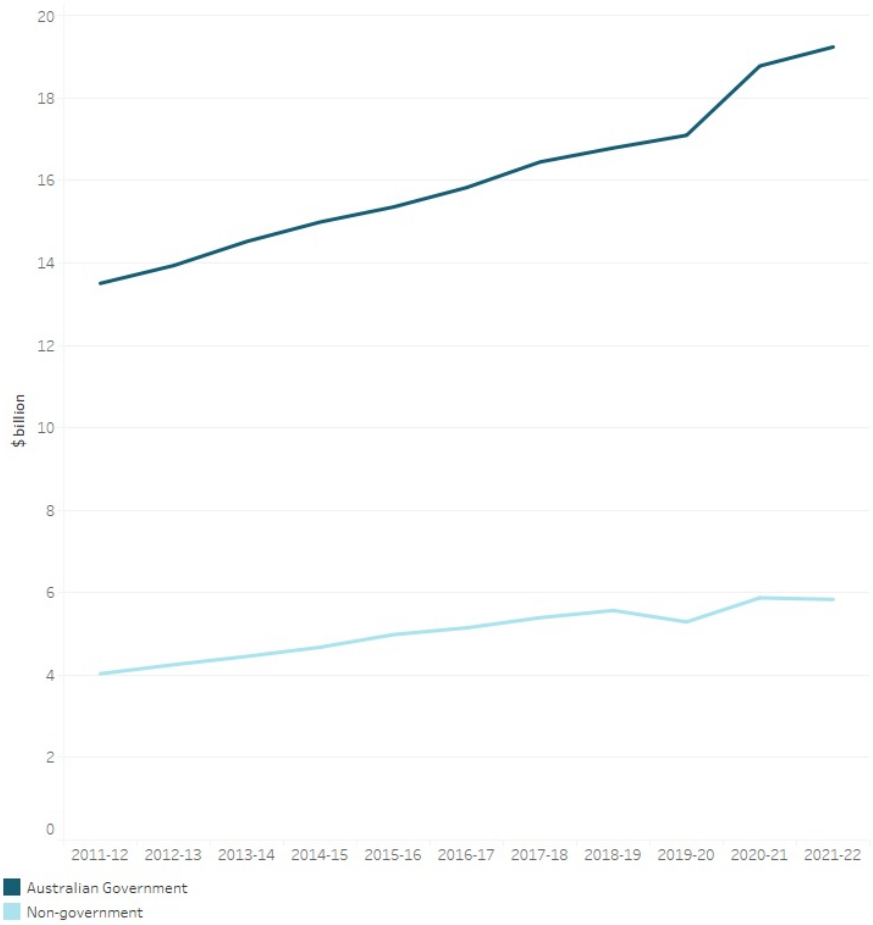
Between 2011–12 and 2021–22, real growth increased by an average of 3.6% each year. The Australian Government spending on primary health care increased the most over the decade, by $14.8 billion, representing an average yearly real growth of 4.6%.

Trends by area of spending

During 2021–22, $25.1 billion was spent on services where a person had been referred by a general practitioner or medical specialist to another non-hospital specialist or allied health professional (this includes services provided in hospitals as discussed in earlier sections of this report). Three in every four dollars were funded by the Australian Government (76.7%, or $19.2 billion) mainly through the MBS, and the remainder by non-government entities (23.3%, or $5.8 billion). State and territory governments do not contribute funding to this area (Figure 28).

Figure 28: Spending on referred medical services, by source of funds, constant prices [(a)], 2011-12 to 2021-22

The line graph shows that spending on referred medical services by both Australian Government and non-government sector over the decade to 2021–22. Australian Government spending was the highest, increasing from $13.5 billion in 2011–12 to $19.2 billion in 2021–22. Non-government spending increased from $4.0 billion in 2011–12 to $5.6 billion in 2018–19, then declined to $5.3 billion in 2019–20 before increased again to $5.8 billion in 2021–22.



[(a)] Constant price health spending is in 2021–22 prices.

Notes:

1. Non-government expenditure consists of individual and health insurance spending only.
2. There was no state and territory government spending on referred medical services.

Source: AIHW Health Expenditure Database (Table 33).

In 2021–22, spending on referred medical services increased by 1.7% from 2020–21 in real terms. Spending by the Australian Government increased by 2.4% ($0.5 billion) while non-government entities decreased by 0.7% ($38 million) in 2021–22.

Over the decade, referred medical expenses increased by an average of 3.6% each year. This was as a result of 3.6% average annual growth by the Australian Government and 3.8% by non-government funding.

Note that when the full in-hospital MBS spending has been allocated to public and private hospital areas in future reports, the spending on referred medical services will be potentially reduced to $21.9 billion (for Australian Government, Private health insurance providers, and Individuals). See MBS in hospitals for more details.

Trends by area of spending

Estimated total spending on other health related services in 2021–22 was $17.1 billion. Of this:

- $6.6 billion was spent on administration
- $5.1 billion on aids and appliances
- $5.4 billion on patient transport services (Table A6).

Overall:

- non-government entities contributed $7.0 billion
- state and territory governments $5.7 billion
- Australian Government $4.5 billion (Figure 29).

Figure 29: Other services [(a)] spending, by source of funds, constant prices [(b)], 2011–12 to 2021–22

The line graph shows that spending on other services by Australian Government, state and territory government and non-government sector over the decade to 2021–22. Non-government spending increased from $5.6 billion in 2011–12 to $6.9 billion in 2018–19, then declined to $6.5 billion in 2019–20 before increased again to $7.0 billion in 2021–22. Australian Government spending increased less steadily, spiking to $3.9 billion in 2011–12 then decreasing to $3.2 billion in the following year, before gradually increasing to $4.1 billion in 2018–19, then was flat around $4.0 billion in 2019–20 and 2020–21 and then increased to 4.5 billion in 2021-22. State and territory government spending increased every year except for 2012–13 and was $3.0 billion in 2011–12 compared to $5.7 billion in 2021–22.

(a) Other services include patient transport services, aids and appliances, and administration.

(b) Constant price health spending is in 2021–22 prices.

Source: AIHW Health Expenditure Database (Table 34).

Compared with 2020–21, spending on other services increased in real terms by $1.3 billion (7.9%) in 2021–22. This growth was attributable mainly to an increase in spending by state and territory governments of $1.1 billion (23.4%). The Australian Government spending increased by $0.5 billion (11.2%) while non-government entities' spending decreased by $0.3 billion (3.8%).

In the decade since 2011–12, the real average annual growth rate on other services was 3.2%.

Trends by area of spending

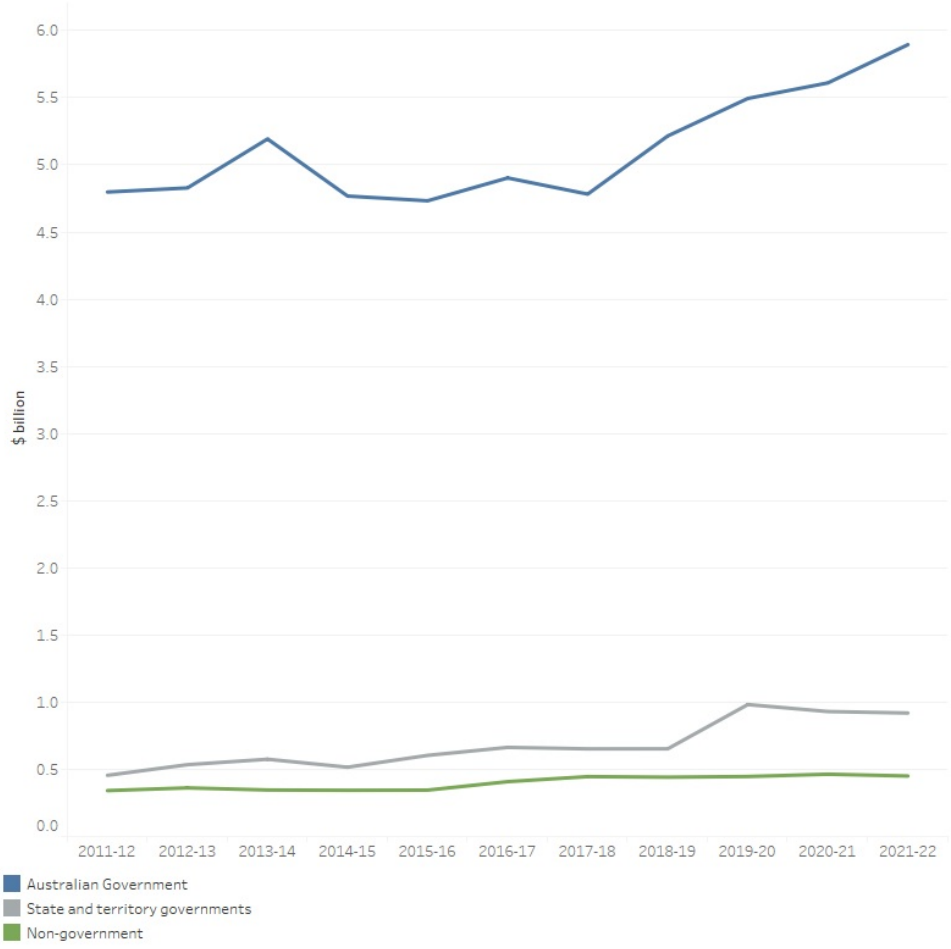
During 2021–22, an estimated $7.3 billion was spent on health and medical research. Of this:

- the Australian Government contributed $5.9 billion (81.1%)
- state and territory governments $0.9 billion (12.7%)
- non-government sector $0.5 billion (6.2%) (Figure 30).

In real terms, spending on research increased by $0.3 billion (3.7%) between 2020–21 and 2021–22.

Figure 30: Research spending, by source of funds, constant prices [(a)], 2011–12 to 2021–22

The line graph shows that Australian Government spending on research was much higher than spending on research by the state and territory governments, which in turn was higher than non-government spending on research over the decade to 2021–22. Australian Government spending fluctuated over the decade, but nonetheless increased from $4.8 billion in 2011–12 to $5.9 billion in 2021–22. State and territory government spending on research increased steadily to $0.7 billion in 2018–19, then peaked to $1.0 billion in 2019–20 and $0.9 billion in 2021–22. Non-government spending was relatively flat across the decade, at about $0.5 billion in 2021–22.



[(a)] Constant price health spending is in 2021–22 prices.

Notes

1. Non-government spending comprises individual and other non-government spending only.
2. There was no spending by private health insurance providers on research.

Source: AIHW Health Expenditure Database (Table 35).

Trends by area of spending

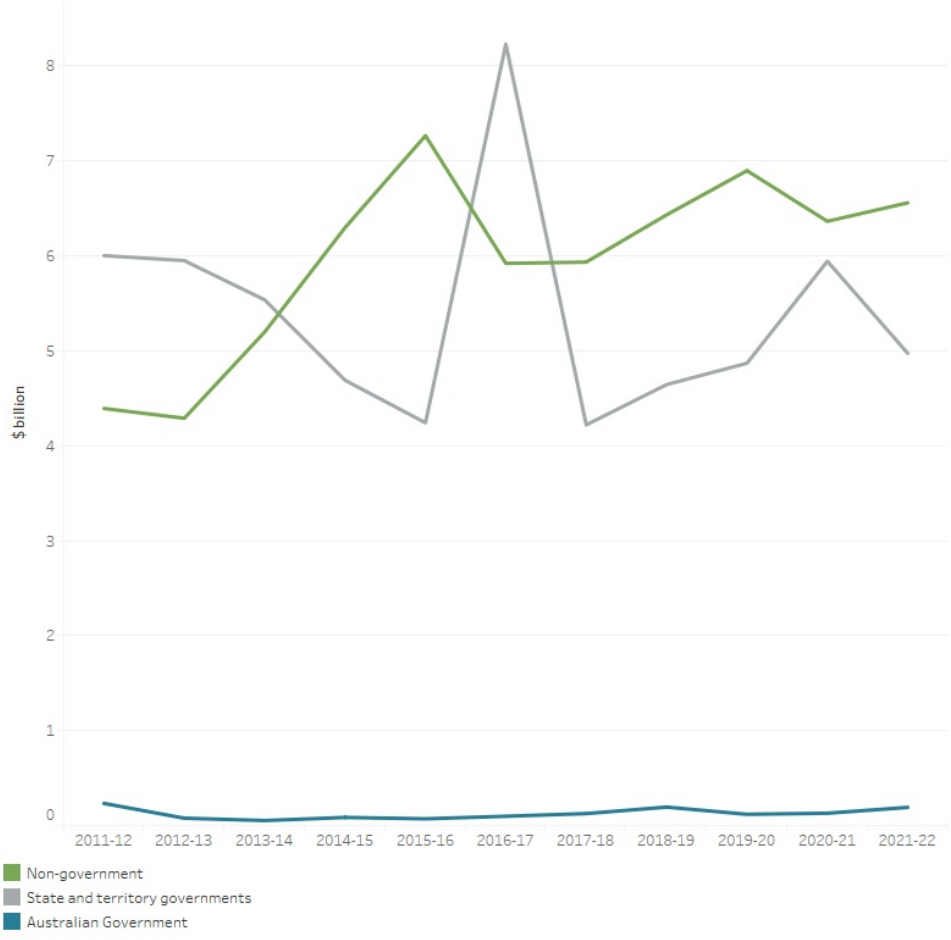
Capital spending is an important component of total health spending. However, capital outlays often relate to relatively high-cost items that have useful lives extending over many years. As such, growth in capital spending from year to year can be difficult to interpret. For example, 2016–17 capital spending estimates were affected by a large amount of capital spending on the new Royal Adelaide Hospital in South Australia. This one-off spending increased 2016–17 data and contributed to the 27.9% decrease in capital spending in 2017–18.

Capital spending on health facilities and investments in 2021–22 was $11.7 billion. Over the decade to 2021–22, spending on capital accounted for around 5.8% of total health spending per year on average (Table 2).

From 2011–12 to 2021–22, capital spending by the non-government sector averaged half (52.0%) of capital spending, state and territory governments averaged 46.9% and the Australian Government averaged 1.1% (Figure 31).

Figure 31: Capital spending, by source of funds, constant prices [(a)], 2011–12 to 2021–22

The line graph shows that capital spending by state and territory governments and non-government has been volatile in the decade 2011–12 to 2021–22. State and territory government spending on capital decreased from $6.0 billion in 2011–12 to $4.2 billion in 2015–16 before spiking to $8.2 billion in 2016–17 and was $5.9 billion in 2020–21 then decreased to 5.0 billion in 2021–22. Non-government spending on capital fluctuated over the decade from $4.4 billion in 2011–12 to $6.6 billion in 2021–22. Australian Government spending on capital has been low and steadily increased over the same period, at $200 million in 2021–22.



[(a)] Constant price health spending is in 2021–22 prices.

Notes:

1. Non-government spending on capital is by other non-government only, with no spending by individuals or private health insurance providers.
2. The increase in 2016–17 for state and territory governments was due to a one-off capital spending project in South Australia.

Source: AIHW Health Expenditure Database (Table 36).

Australian Government
Australian Institute of Health and Welfare

Main visualisations

Main visualisations

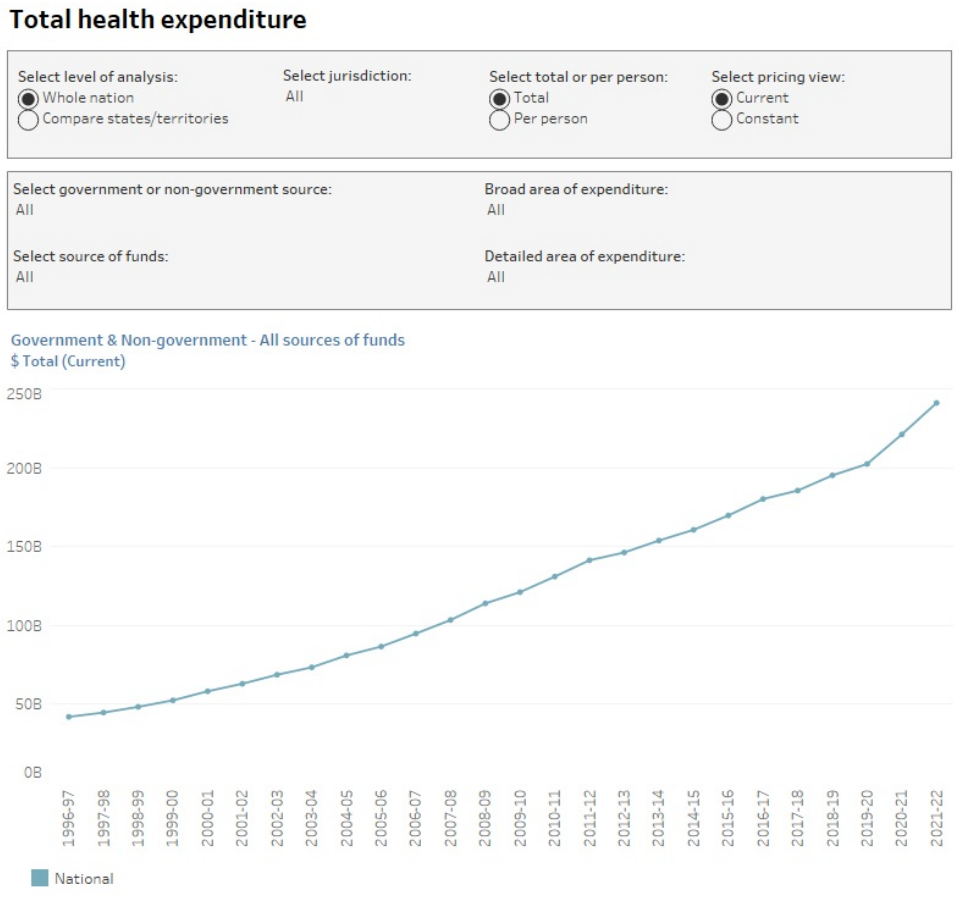
This visualisation represents an overview of total health spending, in constant prices or current prices in Australia as a whole nation as well as each state and territory.

Visualisation 1: Overview

'Overview' tab represents an overview of total health spending, constant prices or current prices in Australia as a whole nation as well as each state and territory in the period from 1996–97 to 2021–22. This tab presents the total health spending by sources of funds and areas of expenditure. The tab also shows health spending per person in Australia as a whole nation as well as each state and territory.

'*Sources and Areas*' tab shows health spending, constant prices or current prices, by areas of spending and source of funds in Australia in the period from 1985–96 to 2021–22. This tab also presents proportions of health spending by sources of funds/areas of spending in the total health spending for Australia.

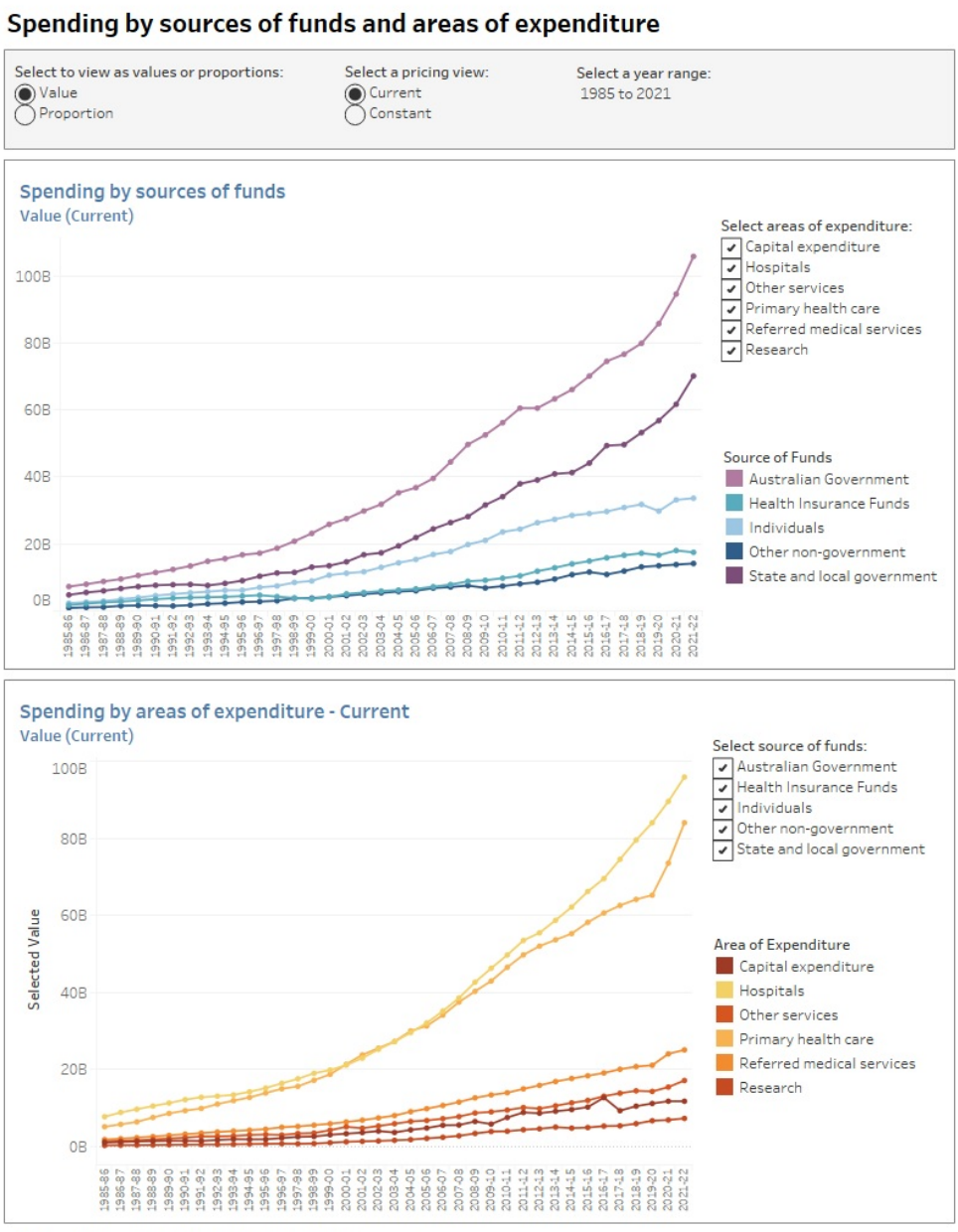
'*Spending by state*' tab illustrates total health spending, constant prices or current prices, by each state and territory, in the period from 1996–97 to 2021–22. This tab also presents health spending per person, constant prices or current prices, by each state and territory, in the period from 1996–97 to 2020–21.



Main visualisations

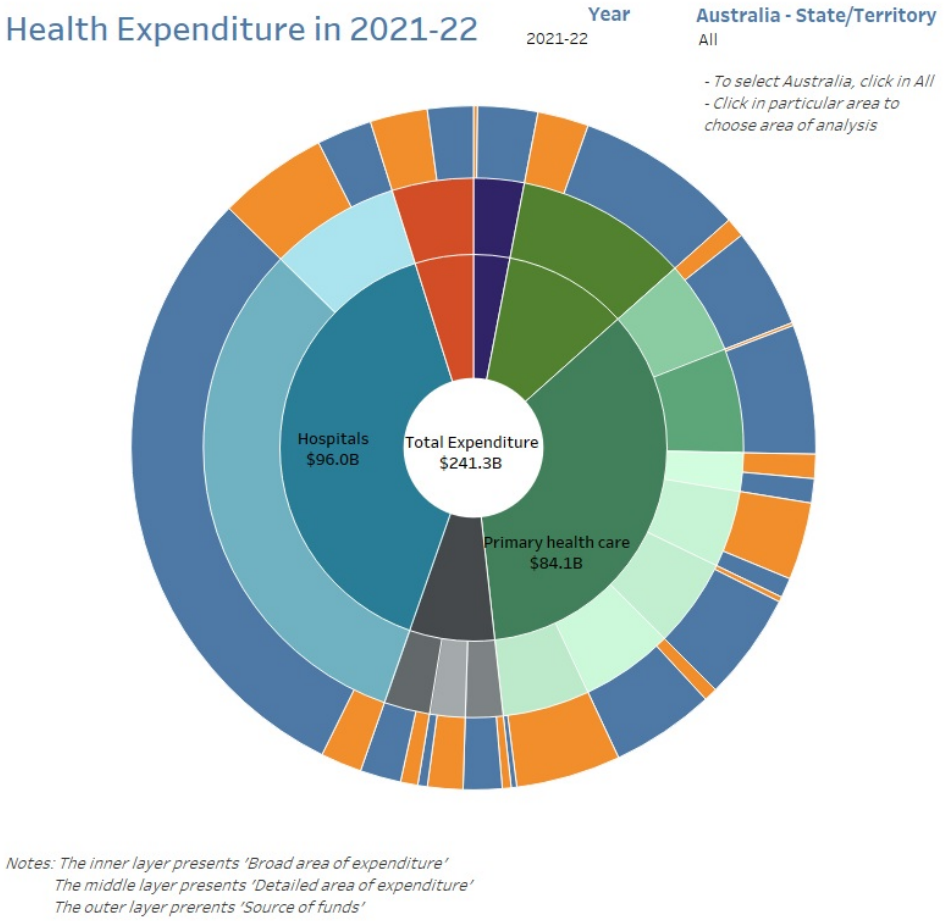
This visualisation shows health spending by source of funds and areas of spending in both line graphs and sunburst ones.

Visualisation 2: Sources and areas

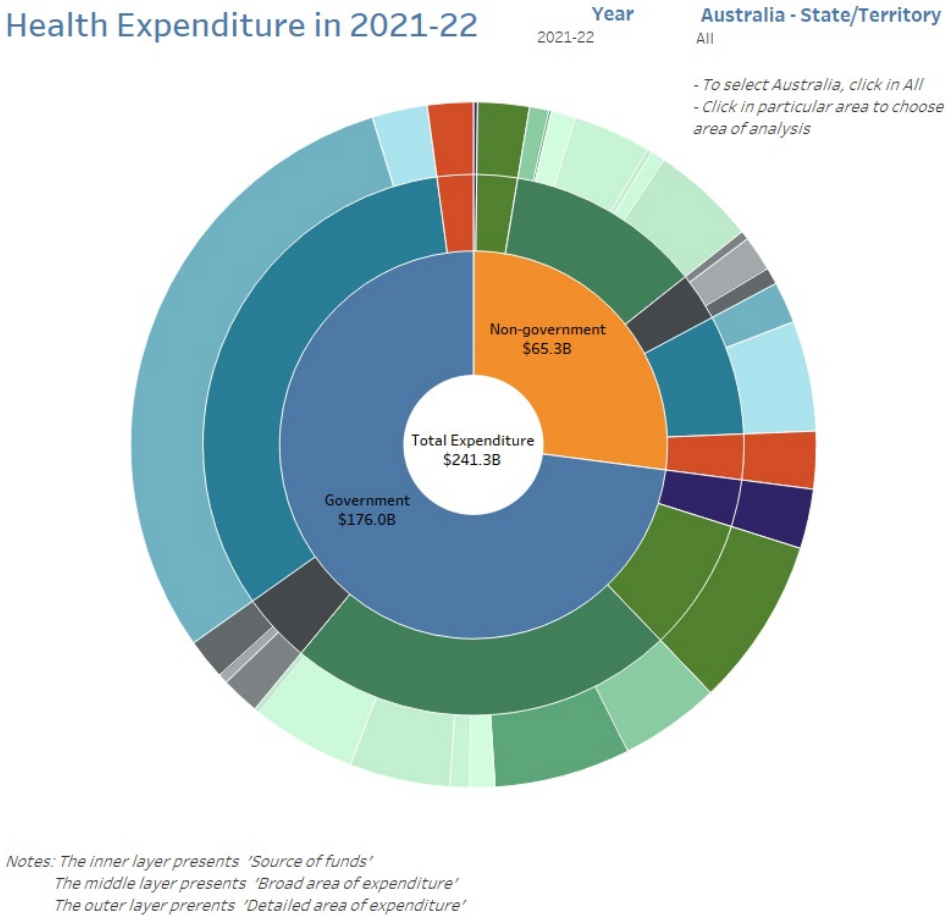


Note: Calculations do not include Medical expenses tax rebate.
Source: AIHW Health Expenditure Database.
http://www.aihw.gov.au

'Sunburst_area_source' graph illustrates the areas of expenditure and source of funds, using constants prices, in the period from 1996-97 to 2021-22. It includes 4 layers, the centre layer presents the total of expenditure for each area or year, the second layer presents broad area of expenditure, the third layer presents detailed area of expenditure, and the outer layer presents the source of funds. For each area of expenditure or source of funds, it can be filtered by year or for Australia or each State/Territory.



'Sunburst_source_area' graph describes the source of funds and area of expenditure, using constants prices, in the period between 1996-97 to 2021-22. It includes 4 layers, the centre layer presents the total of expenditure for each area or year, the second layer presents source of fund, the third layer presents broad area of expenditure, and the outer layer presents the detailed area of expenditure. For each area of expenditure or source of funds, it can be filtered by year or for Australia or each State/Territory.



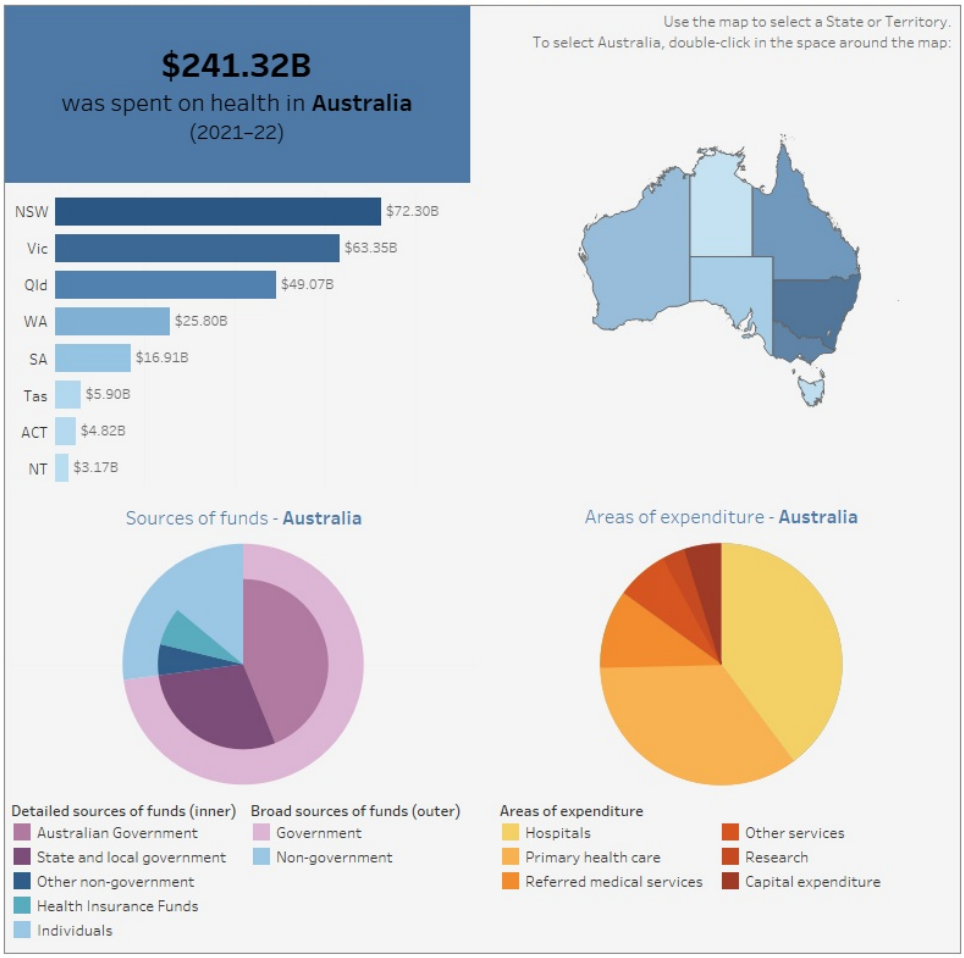
Main visualisations

This visualisation illustrates total health spending and health spending per person, in constant prices or current prices, by each state and territory.

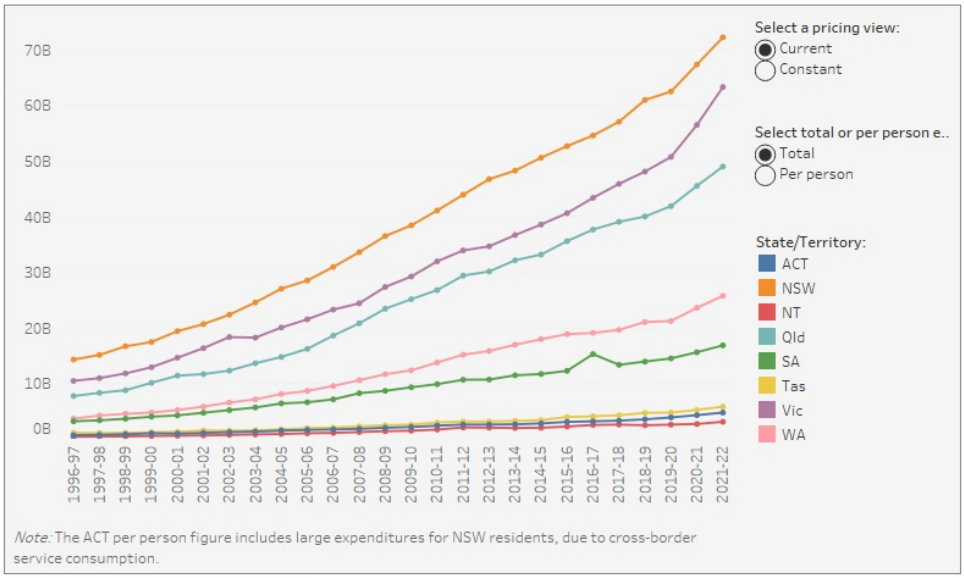
Visualisation 3: Spending by state

'*Spending by state*' tab illustrates total health spending, constant prices or current prices, by each state and territory, in the period from 1996–97 to 2021–22. This tab also presents health spending per person, constant prices or current prices, by each state and territory, in the period from 1996–97 to 2021–22.

Total health expenditure by location 2021–22



Trend in health expenditure by location, 1996–97 to 2021–22



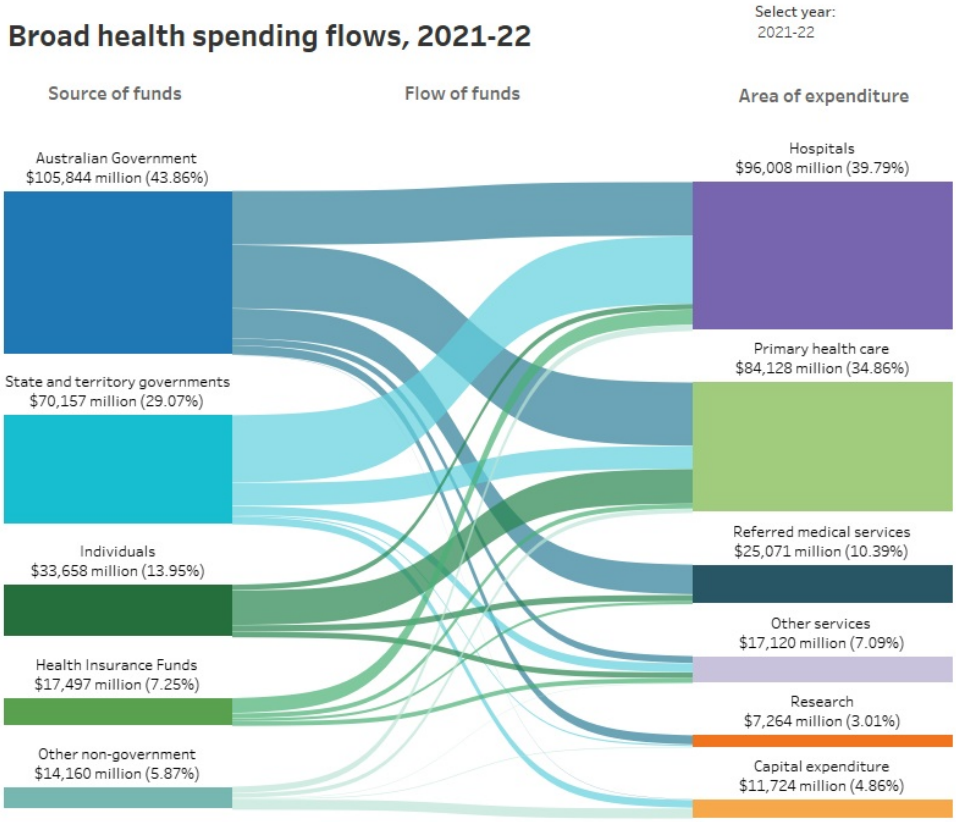
Source: AIHW Health Expenditure Database.
http://www.aihw.gov.au

Main visualisations

This visualisation shows diagrams on health spending flows in current prices from sources of funds into broad areas of expenditure.

Visualisation 4: Broad flows

'*Broad flows*' tab shows diagrams on health spending flows in current prices from sources of funds such as Australian Government, state and territory governments, Individuals, Health insurance funds and Other non-government into areas of expenditure: Hospitals, Primary health care, Referred medical services, Other services, Research and Capital expenditure. The diagrams cover the period from 1985–86 to 2021–22.



Notes
1. This analysis excludes spending on the medical expenses tax rebate.
2. Health spending is in current prices.

Source: AIHW Health Expenditure Database.
http://www.aihw.gov.au

Main visualisations

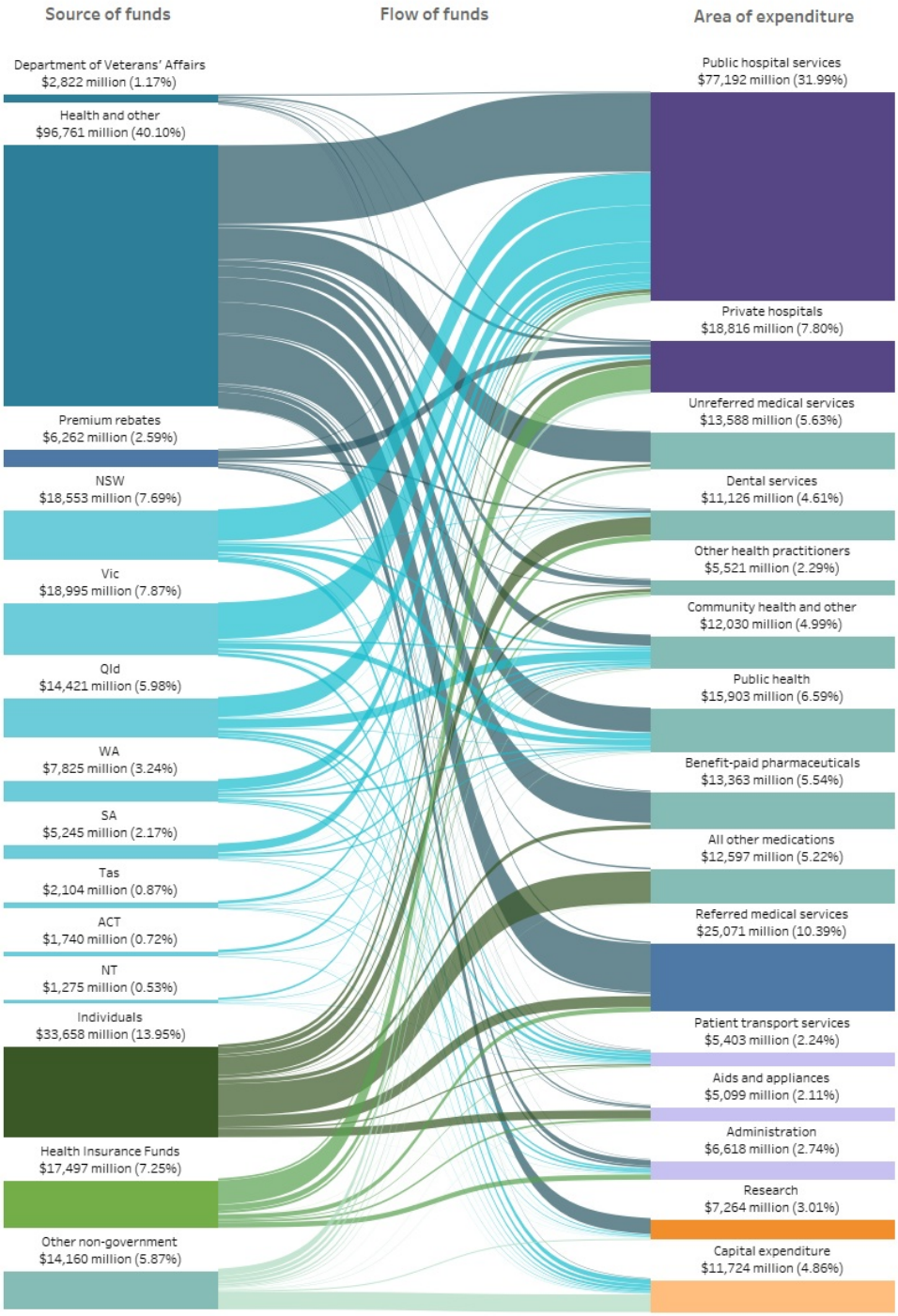
This visualisation tab shows diagrams on health spending flows in current prices from detailed sources of funds into detailed areas of expenditure.

Visualisation 5: Detailed flows

'*Detailed flows*' tab shows diagrams on health spending flows in current prices from detailed sources of funds such as Department of Veterans' Affairs, Health and other, Premium rebates, state and territory governments (NSW, VIC, QLD, WA, SA, TAS, ACT and NT), Individuals, Health insurance funds and Other non-government into areas of expenditure: Public hospital services, Private hospitals, Unreferred medical services, Dental services, Other health practitioners, Community health and other, Public health, Benefit-paid pharmaceuticals, All other medications, Referred medical services, Patient transport services, Aids and appliances, Administration, Research and Capital expenditure. The diagrams cover the period from 1996–97 to 2021–22.

Detailed health spending flows, 2021-22

Select year:
2021-22



Notes

1. This analysis excludes spending on the medical expenses tax rebate.
2. Health spending is in current prices.
3. 'Health and other' figures include Australian Government Department of Health and Aged Care's own programs, grants to states and territories (including National Health Reform grants, National Partnership of COVID-19 Response grants, PBS section 100 programs in public hospitals, and other National Partnership Payments), funding by other Australian Government agencies (including Department of Defence, capital consumption, and others).
4. 'Premium rebates' figures comprise health insurance rebates claimed through the taxation system, as well as rebates paid directly to health insurance funds by the Australian Government that enable them to reduce premiums. See "Overview of data sources and methodology" (Column C, M and G) for further details on how health expenditure is estimated from total premium rebates.

Source: AIHW Health Expenditure Database.
http://www.aihw.gov.au

Main visualisations

This table represents detailed expenditure table in constant prices or current prices by each state and territory in each year.

Visualisation 6: Expenditure table

'*Table*' tab represents detailed expenditure table in constant prices or current prices by each state and territory in the period from 1996-97 to 2021-22 The detailed table present health spending by sources of funds and areas of expenditure in each year.

Total health expenditure by area of expenditure and source of funds ($ million)

Use the drop down filters below to select the data you would like to view.

You can drill both down and up in the table below by either right clicking on a column/row and selecting 'Drill down' or 'Drill up' or by clicking the ⊟ or ⊞ buttons when hovering over the table headings.

Select year: 2021-22

Select level of analysis: All

Select price view: Constant prices

Recurrent/ Capital expenditure	Broad area of expenditure	Detailed area of expenditure	Government		Non-government			*Total health expenditure*
			Australian Government	State and local government	Health Insurance Funds	Individuals	Other non-government	
Recurrent expenditure	Hospitals	Private hospitals	5,061	1,220	8,894	2,244	1,397	18,816
		Public hospital services	29,864	42,617	766	1,247	2,698	77,192
		Total	34,925	43,837	9,660	3,491	4,095	96,008
	Other services	Administration	2,930	1,731	1,935	16	5	6,618
		Aids and appliances	1,077		757	3,125	140	5,099
		Patient transport services	470	3,956	319	524	133	5,403
		Total	4,478	5,688	3,012	3,665	278	17,120
	Primary health care	All other medications	632		44	11,818	103	12,597
		Benefit-paid pharmaceuticals	11,795			1,568		13,363
		Community health and other	4,137	7,315	1	194	383	12,030
		Dental services	1,301	963	2,156	6,661	46	11,126
		Other health practitioners	2,765	9	887	1,154	707	5,521
		Public health	9,112	6,453		75	263	15,903
		Unreferred medical services	11,377			933	1,279	13,588
		Total	41,120	14,739	3,088	22,401	2,779	84,128
	Referred medical services	Referred medical services	19,236		1,737	4,098		25,071
		Total	19,236		1,737	4,098		25,071
	Research	Research	5,895	919		2	448	7,264
		Total	5,895	919		2	448	7,264
	Total		105,653	65,183	17,497	33,658	7,600	229,591
Capital expenditure	Capital expenditure	Null	191	4,974			6,559	11,724
		Total	191	4,974			6,559	11,724
	Total		191	4,974			6,559	11,724
Medical expenses tax rebate	Medical expenses tax rebate	Null	0			0		0
		Total	0			0		0
	Total		0			0		0
Total health expenditure			105,844	70,157	17,497	33,658	14,160	241,316

Note: In Level of analysis, "All" means national level.

Source: AIHW Health Expenditure Database.
http://www.aihw.gov.au

Overview of data sources and methodology

Australian National Health Account: concepts, methodology and data sources

The *Australian National Health Account: concepts, methodology and data sources* provides information to accompany annual reporting of health expenditure by the Australian Institute of Health and Welfare (AIHW) in *Australia's health expenditure*. The latest reporting period relates to expenditure in the decade to 2021–22.

There are 3 main sections to this document:

1. The Australian National Health Account is a brief overview of estimating health expenditure in Australia.
2. Concepts and definitions explain elements of the structure of the health system and the flow of funds within it, as well as important concepts used in the reporting of health expenditure estimates.
3. The compilation of health expenditure estimates covers details of how the estimates are derived from the wide range of data sources used.

Overview of data sources and methodology

On this page:

Overview

The Australian National Health Account (ANHA) is an annual financial-year estimate of health expenditure in Australia, produced by the AIHW. It is published in the Health expenditure Australia (HEA) report series as well as forming the basis of Australia's submission to the Organisation for Economic Cooperation and Development and World Health Organisation annual health accounts collection.

Health expenditure is defined as spending on health goods and services, which includes medical care (both in and out of hospital); pharmaceuticals; public health; rehabilitation; community health activities; health administration and regulation; health research; and capital formation.

The estimate of health expenditure reported in HEA provides information disaggregated by both funding source and area of health spending, reflecting the structure of funding in the Australian health system (Figure 32).

Broadly, HEA presents the latest expenditure information, as well as trends for:

- the total amount spent on health in Australia, in current and constant prices
- the amount spent by the source of fundings including Australian Government, state and territory governments and non-government sources
- the amount spent on different types of health goods and services ("areas of expenditure"), such as hospitals, primary health care, referred medical services, health and medical research and capital expenditure.

The AIHW has been reporting on health spending for more than three decades. However, measuring health expenditure in Australia first began in the 1970s. A history of health expenditure data development in Australia can be found in Australian national health and welfare accounts: concepts and data sources (AIHW 2003).

Other health expenditure estimates

The ANHA aims to support a long term, whole-of-system understanding of national health spending, and where possible classifies health expenditure in terms of the Organisation for Economic Co-operation and Development's system of health accounts (OECD SHA) categories (AIHW 2003). The 3 key dimensions of the OECD SHA classification system are health care by functions of care; providers of health care services; and health care financing scheme.

There are other estimates of health funding and expenditure in Australia, including those produced by the Australian Bureau of Statistics (ABS). There are also sources of data from specific funding programs and bodies, such as those of the National Health Funding Body (NHFB) and large funding programs like the Medicare Benefits Scheme (MBS). However, the ANHA varies from these in a variety of ways, including its scope (other estimates tend to focus on specific funding programs, jurisdictions or time periods) and, methodology and classification system used to derive estimates.

To better understand the differences in reported estimates, refer to Comparison and alignment of Australian health expenditure estimates and Understanding the different approaches to reporting Australian health expenditure (ABS & AIHW 2019).

What is not included in the estimates

The health expenditure estimates from the ANHA do not currently include:

- some local government spending
- health spending by some non-government organisations, such as the National Heart Foundation and Diabetes Australia
- occupational health spending by non-government sources such as private enterprises
- spending on the health-care component of high-level residential care.

Education and training of health professionals and many forms of spending with an outcome that would indirectly impact health – such as the production of more nutritious food, road safety or law and order – are also not included.

Data sources

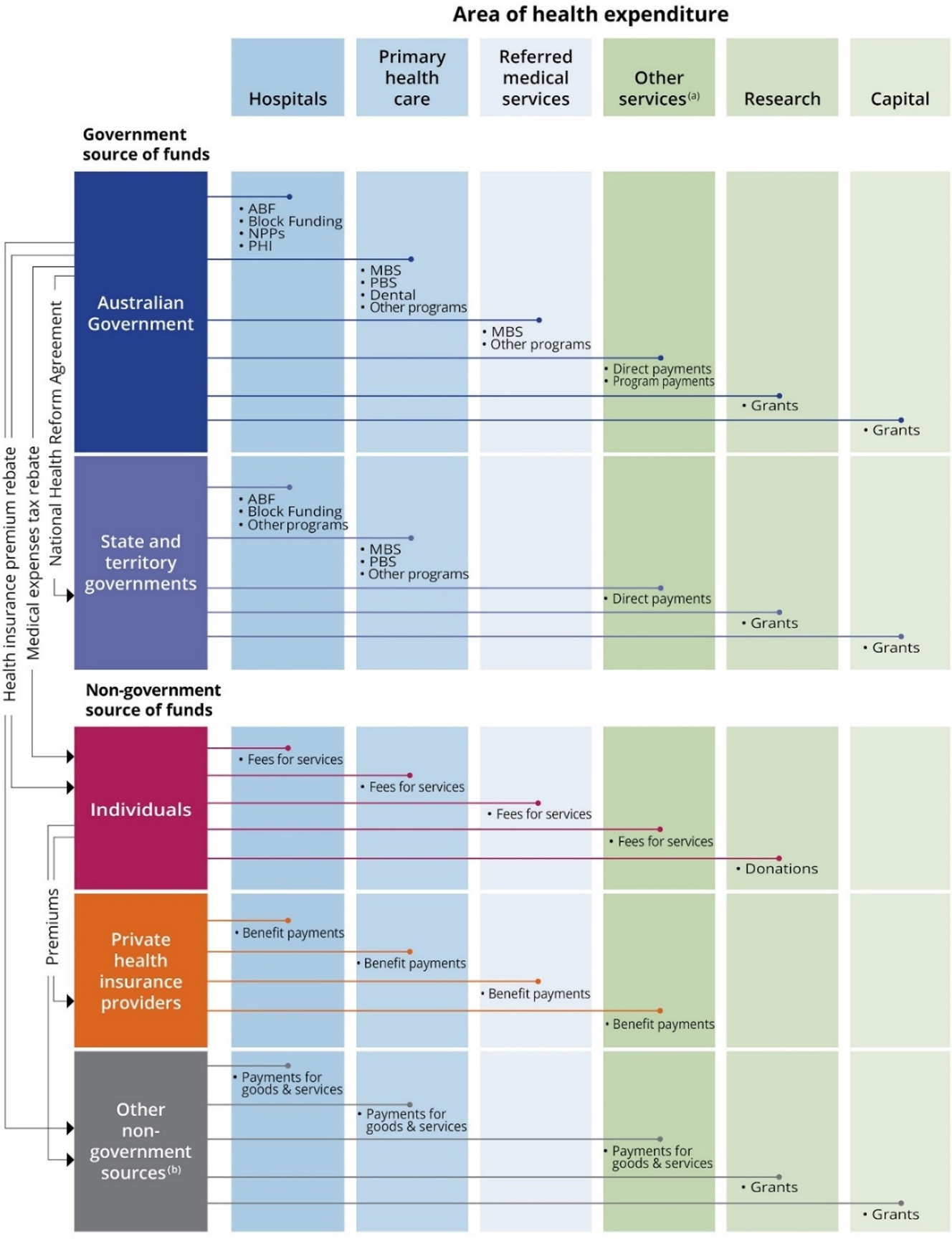
The ANHA is derived from more than 50 data sources capturing health spending by governments, individuals, insurance providers and other private sources, such as some private hospital spending and research. The expenditure estimates are collated and stored in the AIHW's Health Expenditure Database (HED).

The data sources are discussed in detail in Data processing and listed in Table T2.

Revisions and data resubmissions

There are often revisions to previously published estimates of health expenditure, due to receipt of additional or revised data from data suppliers, or changes in estimation methods. The AIHW typically provides back-casting for any changes in the methodology or data sources. As a result, comparisons over time should be based on the estimates provided in the most recent publication.

Figure 32: The structure and funding of Australia's health system



Overview of data sources and methodology

- **On this page**
- Government funding sources
- Non-government funding sources
- Areas of spending
- Deflators

Government funding sources

Australian Government

The Australian Government health funding includes: the Medicare Benefits Schedule (MBS); the Pharmaceutical Benefits Scheme (PBS); supporting and regulating Private Health Insurance (PHI); monitoring the quality, effectiveness and efficiency of primary health care services; funding health and medical research; funding veterans' health care through the Department of Veterans' Affairs (DVA); funding community controlled Aboriginal and Torres Strait Islander primary health care organisations; buying vaccines for the national immunisation program; and subsidising hearing services. It also funds the Department of Health and Aged Care (DoHAC), Services Australia (who deliver government payments and services), universities and other health-related bodies on health and medical research, and private health insurance premium rebates. Up until 2018–19 when it ceased, the Australian Government also funded the net medical expenses tax rebate (the small amount presented in 2019–20 related to late claims/processing).

The Australian Government shares responsibilities with the states and territories for activities including: funding public hospital services; preventive services, such as cancer screening programs; funding palliative care; and national mental health reform. Funding is provided from the Australian Government under the National Health Reform Agreement (NHRA) and for specific projects and priority areas through the National Partnership Agreement (NPA) on health services (Box 2.1).

Australian Government funding to the states and territories occurs primarily under the National Health Reform Agreement (NHRA) and (Box 2.1).

Most Australian Government spending can be readily allocated on a state and territory basis:

- National Health Reform (NHR) funding (referred to as the National Healthcare Specific Purpose Payments before 1 July 2012)
- health-related National Partnership Payments (NPP) to the states and territories
- MBS and PBS payments, and most DVA spending (based on residence of patient).

Other Australian Government health spending is generally not explicitly allocated to states and territories. In these cases, estimation methods are used to derive state and territory spending. For example, non-MBS payments to primary health care medical service providers are allocated according to the proportion of vocationally registered general practitioners in each state or territory.

Box 2.1: Australian Government funding to states and territories

Australian Government funding to the states and territories is through two agreements: the NHRA and the NPA on health services.

National Health Reform Agreement

The NHRA, signed in 2011, outlines the shared roles of the Australian Government and state and territory governments to work in partnership to improve health outcomes and ensure the sustainability of the health system. It recognises the states and territories as the managers of the public hospital system and the Australian Government as having a lead role for delivering general practitioner (GP) and primary health care.

The NHRA was initiated to improve patient access to services and public hospital efficiency through Activity Based Funding (ABF); improve the transparency of public hospital funding through the National Health Funding Pool (NHFP); improve standards of clinical care through the Australian Commission on Safety and Quality in Health Care; improve performance reporting through the NHPA; improve accountability through the Performance and Accountability Framework; improve local accountability and responsiveness to the needs of communities through the Local Hospital Networks and Medicare Locals; and improve the provision of GP and primary health care services through better integrated systems.

There are two types of NHR funding: ABF is a way of funding hospitals whereby they get paid for the number and mix of patients they treat. Block funding supports teaching, training and research in public hospitals, and public health programs. It is also used for certain public hospital services where block funding is more appropriate, particularly for smaller rural and regional hospitals.

National Partnership Agreement on health services

NPPs are paid under the NPA on health services aimed at improving the health and well-being of Australians through delivering high quality health services. The amount the Australian Government pays to each state and territory is determined by specified performance benchmarks related to each bilateral agreement.

NPPs fall under the following categories:

- health services, such as additional assistance for public hospitals; comprehensive palliative care across the life course; expansion of the BreastScreen Australia program

- health infrastructure, such as upgrade of Ballina Hospital (NSW) and Albury-Wodonga Cardiac Catheterisation Laboratory

- Indigenous health, such as the NT remote Aboriginal investment – health component and the Rheumatic fever strategy

- other health payments, including Community Health, Hospitals and Infrastructure projects, Encouraging more clinical trials in Australia, the Health Innovation Fund, Public dental services for adults and Suicide prevention.

Since 2019–20, the Australian Government also contributes funding to states and territories under the National Partnership on COVID-19 Response (NPCR), which includes funding in public hospitals, private hospitals, public health, patient transport, community health, and minor capital expenditure.

Department of Veterans' Affairs

DVA funds health-related services and programs for eligible veterans, their families and their carers. DVA-supported health services and treatments include:

- hospital services
- mental health services
- various medical and allied health services
- rehabilitation support (including adaptive equipment, aids and appliances, and support to return to work)
- benefit-paid pharmaceuticals.

Health services are provided under the: *Veterans' Entitlements Act 1986*; *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988*; *Military Rehabilitation and Compensation Act 2004* (MRCA) and services that qualify for benefit under the Department of Veterans' Affairs National Treatment Account.

DVA issues various health cards that entitle holders to a range of health service benefits. Eligibility for DVA funded heath support is dependent on whether an entitled person holds a Veteran Gold or White Card.

Medical expenses tax rebate

The medical expenses tax rebate (or net medical expenses tax offset) was an Australian Government subsidy to assist with the cost of medical expenses that was phased out at the end of 2018–19 (ATO 2020a). Prior to this, taxpayers who spent large amounts of money on health-related goods and services were able to claim a tax rebate.

Before 2012–13, the tax rebate was 20 cents in the dollar and applied to the amount spent over the threshold for a financial year. From July 2012, the tax rebate became means tested. In March 2014, eligibility for it changed again, restricting who could claim and the type of medical expenses that could be claimed.

The rebate is shown as being funded by the Australian Government, and therefore the original expenditure made by individuals is deducted from individual spending. However, it is not possible to allocate funding to specific categories of health spending as the areas of spending the rebate funded cannot be identified separately.

Private health insurance premium rebates

The private health insurance (PHI) premium rebate is a refund on PHI premiums paid by individuals. It replaced the Private Health Insurance Incentives Scheme subsidy in 1999.

The rebate is regarded as an indirect Australian Government subsidy of all the types of services funded through PHI. It includes rebates paid either to health insurance providers when individuals have paid a reduced premium, or through the tax system when individuals have paid the full premium (Box 2.2).

In the ANHA, the premium rebate is pro-rated across all expense categories. Since not all revenues that PHI providers receive are spent on health goods and services for their members (and not therefore considered health expenditure), the rebate amount reported in the HEA is an estimate of the rebate (direct and through the tax system) paid out through health benefits. It is therefore smaller than the total rebate paid to individuals to reduce premiums, which are reported elsewhere, such as by DoHAC and Australian Taxation Office (ATO) annual reports. See the Data processing section for more details on the estimation.

Defence force spending

The HED 2021–22 includes health expenditure by the Australian Department of Defence (Department of Defence, Joint Health Command 2021), which started providing data since the 2019–20 report.

State and territory governments

State and territory governments are taking the main role for: management and administration of public hospitals, with shared funding arrangements with the Australian Government through the NHR funding; delivery of preventive services such as breast cancer screening and immunisation programs; funding and management of community mental health services; public dental clinics; and ambulance and emergency services.

Each jurisdiction provides information about health expenditure through the Government Health Expenditure National Minimum Data Set (GHE NMDS). These data are supplied on an accrual basis: expenditure is recorded when a good or service has been delivered rather than at the point that payment is made.

More information on the GHE NMDS is on the AIHW's Metadata Online Registry.

When state and territory governments receive funding from the Australian Government, such as NHR funding and health-related NPPs, the expenditure is reported as spending by the Australian Government. The corresponding amount is deducted, or offset, from the state or territory government to remove double counting.

Comparing state and territory data

Caution should be exercised when comparing results between states and territories. Where possible, consistent estimation methods and data sources have been applied, but some differences in the data on which estimation methods are based exist between jurisdictions.

Estimating per person spending

Health spending estimates for individual states and territories may include health goods and services provided to patients from other states and territories (except for public hospital spending, where adjustments have been made through the NHR funding to account for cross-border service provision). In calculating spending per person, the population that provides the denominator is the estimated resident population of the state or territory in which the spending was incurred. Since not all cross-border goods and services can be accounted for, this can lead to an overestimation or underestimation of spending per capita in each state and territory.

Health expenditure estimates per person for the Australian Capital Territory (ACT) should be treated with some caution as the ACT provides a high volume of services to New South Wales (NSW) residents.

Local governments

Health spending data are not collected separately from local government authorities. Where these authorities received funding from the Australian Government or state or territory governments, it is included as spending from that body.

Own source funding by local government authorities is not included.

Goods and services tax in government revenues

The goods and services tax (GST) is collected by the Australian Government on behalf of states and territories and then distributed to them. Therefore, Australian Government tax revenues exclude revenues from GST, while state and territory tax revenues include GST.

Non-government funding sources

Private health insurance providers

Individuals pay fees (premiums) to PHI providers, who subsidise treatment and hospital costs in private hospitals or as a private patient in public hospitals and some primary health care services not covered under the MBS (such as dental, optometry and physiotherapy). Premiums are partly subsidised by the Australian Government, which provides eligible members with a rebate (Box 2.2).

Box 2.2: Private health insurance premium rebate

Two mechanisms exist for rebates on PHI premiums:

- PHI providers offer members a reduced premium and then claim reimbursement from the Australian Government.

- PHI members pay the full premium and claim the rebate through the tax system at the end of the financial year.

The PHI rebate on premiums paid by individuals was introduced in 1999, initially providing a 30% discount for people aged under 65, with older Australians received higher rebates.

In July 2012, the Australian Government introduced income testing of the rebate by creating income thresholds (income tiers). These thresholds attracted different rebate levels. This meant higher income earners would progressively receive lower rebates, or no rebate.

In 2014, the Australian Government changed the way the rebate was calculated, resulting in a lower rebate being available. Since then, the rebate has progressively declined. For example, in 2014 it ranged from around 29% for lower income earners (Base tier rate) to no rebate for highest income earners (Tier 3). In 2018, the Base tier rebate was 25%.

Also in 2014, income tiers that had been indexed annually until 2014–15 were frozen. In the 2016–17 Budget, the Australian Government announced it would maintain this freeze until 2021. This has the effect of decreasing rebates if incomes are rising.

Sources: Biggs 2017; Australian Taxation Office (ATO) 2020b.

Health spending by PHI providers are the amounts paid to health care providers. To avoid double counting, PHI provider spending estimates do not include the subsidies from the Australian Government through health insurance premium rebates – the subsidy amount is subtracted from total spending of PHI providers and is attributed to the Australian Government. This results in total PHI provider spending that is less than the amount paid out.

The spending also shows the payments made by PHI providers over the year, which may not align with the timing of the health services being funded.

Private health insurance provider spending by states and territories

PHI provider health spending for each state and territory is assumed to be equal to the amount of benefits paid by PHI providers to PHI members who live in that state or territory minus the private health insurance premium rebate.

Australian Capital Territory

Before 2010–11, data on PHI spending for the ACT were included in the total for NSW. To estimate spending for the ACT, the AIHW used the ACT's admitted patient separation numbers for public and private hospitals to derive its proportion of total ACT and NSW separations. It then applied this proportion to PHI spending.

From 2010–11, PHI expenditure data for the ACT have been available separately; however, these figures have not been used retrospectively to update earlier data.

Individuals

Most non-government funding for health goods and services in Australia comes from out-of-pocket payments by individuals.

Individuals incur medical costs through:

- co-payments (or out-of-pocket expenses) for subsidised goods and services – for example, co-payments for specialist services subsidised through the MBS and medications through the PBS
- co-payments for the cost of health goods and services with third party payers – for example, PHI providers
- co-payments for treatment in a private hospital or as a private patient in a public hospital
- meeting the full cost of goods and services – for example, medications the PBS or RPBS does not subsidise and over-the-counter medications.

Individual spending estimates do not include the premiums paid to PHI providers as these do not in themselves constitute spending on health goods and services. Private health insurance premiums play the role as the main revenue source for PHI providers. PHI health benefits paid out to members are counted as PHI's health spending, as discussed above.

Estimates of individuals' spending on dental services, other health practitioners, and aids and appliances rely mostly on the growths in the PHI cost of services and the growth of the proportion of the population who have general treatment cover through PHI from year-to-year, and historical data. Benefits that individuals received from PHI, Medicare and injury compensation insurers are offset from the total estimates to derive the out-of-pocket spending.

Individual spending on over-the-counter medications is sourced primarily from Information Resources Incorporated (IRI), a private research organisation. State and territory level spending is derived using proportions in historical ABS Household Final Consumption Expenditure (HFCE).

In some states and territories where individual spending appears to be negative (such as expenditure on private hospitals or other services), it can be interpreted that individuals are *subsidised* by another funding sources, including DVA, PHI providers, workers' compensation and compulsory third party motor vehicle insurance (CTPI) providers.

Workers compensation insurance providers

Workers compensation is a form of insurance payment to employees if they are injured at work or become sick due to their work. It can include payments to cover medical expenses and rehabilitation costs, and lump sum payments where an injury is deemed permanent. It can also include payments to families for work-related deaths.

Workers' compensation laws are based on a 'no fault' principle and benefits can include compensation of earnings, medical and hospital treatment, rehabilitation, legal costs, and lump sum payments. The arrangements for workers' compensation differ across states and territories in relation to scheme funding, access to legal advice or representation, coverage and eligibility, level of entitlements and return to work policies.

There are also two federal workers' compensation insurance systems that apply to certain types of workers, one for approved workers in the Comcare system (employees of Australian Government agencies and authorities; employees of national companies licensed by the Safety, Rehabilitation and Compensation Commission.

Expenditure by providers of workers' compensation relates to benefit payments to providers of health goods and services, such as: medical, dental, hospital, ambulance and other professional services; pharmaceuticals; and aids and appliances. The expenditure estimates do not include amounts paid in respect of future medical costs.

Workers' compensation payments data are obtained from Comcare and the respective injury compensation insurance regulatory authorities in each state and territory (Box 2.4). Data from the GHE NMDS are also used for workers' compensation estimates in Queensland (QLD), Western Australia (WA), South Australia (SA) and the Northern Territory (NT).

Box 2.3: State and territory workers' compensation insurance regulatory authorities

New South Wales: State Insurance Regulatory Authority (NSW)

Victoria: WorkSafe Victoria

Queensland: WorkCover Queensland

Western Australian: WorkCover WA

South Australia: ReturnToWorkSA

Tasmania: WorkSafe Tasmania

Australian Capital Territory: WorkSafe ACT

Northern Territory NT WorkSafe

Norfolk Island: Norfolk Island workers compensation agency (data unavailable)

Compulsory third party motor vehicle insurance providers

CTPI provides compensation for anyone injured or killed in a motor vehicle accident. Compensation can include medical and rehabilitation expenses, loss of income, damages for any disability caused by the accident, damages to immediate family in the event of death, and legal expenses.

Expenditure by CTPI providers relates to benefit payments to providers of health goods and services, such as: medical, dental, hospital, ambulance and other professional services; pharmaceuticals; and aids and appliances. The expenditure estimates do not include amounts paid in respect of future medical costs.

CTPI payments data are obtained from the respective compulsory third-party insurance regulatory authorities in each state and territory (Box 2.4). Data from the GHE NMDS are also used for workers' compensation estimates in WA, SA and the NT.

Box 2.4: State and territory compulsory third-party insurance regulatory authorities

New South Wales: The State Insurance Regulatory Authority

Victoria: Transport Accident Commission

Queensland: Motor Accident Insurance Commission in Queensland

Western Australia: Insurance Commission of Western Australian

South Australia: Motor Accident Commission

Tasmania: Motor Accidents Insurance Board

Australian Capital Territory: ACT compulsory third party insurance regulator (data unavailable)

Northern Territory: Territory Insurance Office

Other private

This component of non-government funding of health goods and services, includes payments such as:

- non-patient revenue that private hospitals receive (for example, from donations)
- university and other research spending funded by non-government sources
- private capital expenditure
- revenue that state and territory governments received from private sources other than individuals.

Areas of spending

Public hospitals

In Australia, public hospitals offer a broad range of free services to eligible admitted and non-admitted patients:

- Admitted patient services are for patients formally admitted to hospital, either on the same day or involving an overnight stay of one or more nights in hospital. They include medical, surgical and other acute care, as well as child birth, mental health and non-acute care.
- Non-admitted patient services are provided in emergency departments and outpatient clinics. They include dispensing medicines, district nursing and some community health services.

Public hospitals and the services they provide are jointly funded by the Australian Government and state and territory governments, complemented by payments from non-government sources. State and territory governments manage and operate public hospital services, which are provided free to public patients. Patients can elect to be treated as either a public or private patient.

Australian Government funds are primarily based on activity levels – ABF (Box 2.1). Public hospitals are administered by the relevant state or territory health authority which provide additional funds for them. Non-government sources provide funds to public hospitals for services such as ambulatory care and programs not covered by the MBS.

State and territory health authorities provide estimates of spending on public hospital services through the GHE NMDS. These reflect public hospital expenses used only in providing hospital services. This can include services provided off-site, such as hospital-in-the-home and dialysis.

Public hospital spending excludes expenses incurred in providing community and public health services, dental, patient transport services, and health research undertaken by public hospitals. The excluded expenses are captured under their respective categories, such as Other services or Primary health care.

In some cases, public hospitals receive fees from medical practitioners in return for the right to practise privately within the hospital. The medical practitioner may then receive payment from the MBS, individuals and/or private health insurance providers for these services. Up to now, public hospital spending estimates have not explicitly treated any MBS spending as public hospital spending (it is treated as spending on 'referred' or 'unreferred' medical services by the AIHW). See more in the MBS in hospitals.

Cross-border service provision

For public hospitals, cross-border ABF under the NHRA is paid directly through the NHFP to the jurisdiction in which services were provided.

PBS Section 100 programs (public hospital)

Australian Government funding for the PBS Section 100 programs for public hospital patients is conditional on prescriber and patient eligibility criteria (Box 2.5). Payments for this program are considered to be spending on Public hospitals where they have been prescribed for a public inpatient of a public hospital.

Private hospitals

Private hospitals cater for patients treated by a doctor of their choice. Patients are charged fees for accommodation and other services provided by the hospital and relevant medical and paramedical practitioners. Acute care and psychiatric hospitals are included, as are private free-standing day hospital facilities.

Private hospitals are largely owned and operated by private (non-government) organisations – either for-profit companies or non-profit organisations. State and territory governments license or register private hospitals.

Until 2018–19, estimates of individual and other private spending on private hospitals come from the annual ABS Private Health Establishments Collection (PHEC), with results published in *Private Hospitals, Australia, 2016–17* (ABS 2018). The 2016–17 ABS PHEC was the final data collection in this series, and spending estimates for 2017–18 were modelled on the 2016–17 data.

From 2018–19, the Private Hospitals Data Bureau (PHDB) (DoHAC 2020) has been used to estimate the patient revenue (individual expenditure) component of private hospitals. The non-patient revenue component is estimated using historical data and the growth of the patient revenue.

Contracting of private hospital services

Private hospital spending also includes spending by private hospitals in providing contracted and/or ad hoc treatments for public patients, where:

- state and territory governments had contracts with private hospitals to provide services to public patients
- individual public hospitals purchased services from private hospitals for public patients.

This expenditure is collected through the GHE NMDS, which includes reporting of funding by state and territory governments for services private hospitals provide.

PBS Section 100 programs (private hospital)

Australian Government funding for the PBS section 100 programs for private hospital patients is conditional on prescriber and patient eligibility criteria (Box 2.5). Payments for this program are considered to be spending on Private hospitals.

Primary health care

Primary health care (PHC) is typically a person's first contact with the health system. It generally encompasses care not related to a hospital visit (although includes a small amount of in-hospital MBS reported as spending on unreferred medical services).

PHC comes under numerous funding arrangements and expenditure on this area of health includes unreferred medical services (for example, GP visits), dental services, other health practitioner services, pharmaceuticals, and community and public health services. Referred non-hospital medical services (for example, specialist visits) are not classified as PHC. PHC includes activities such as prevention, health promotion, early intervention, treatment of acute conditions and management of chronic conditions.

Unreferred medical services

Unreferred medical services are those provided to a person by, or under the supervision of, a medical practitioner that have not been referred to that practitioner by another medical practitioner or person with referring rights. For example, visits to a GP.

A small proportion of in-hospital MBS – less than 1% of all in-hospital MBS – is reported as unreferred medical services. These include in-hospital:

- GP attendances
- practice nurses
- enhanced primary care
- other unreferred attendances.

Dental services

Dental services are services provided by registered dental practitioners. They include oral and maxillofacial surgery items, orthodontic, pedodontic and periodontic services, cleft lip and palate services, dental assessment and other dental items listed in the MBS. They cover services funded by health insurance funds, state and territory governments and individual out-of-pocket expenses.

Other health practitioners

These include practice nurses, chiropractors, optometrists, physiotherapists, occupational therapists, speech therapists, audiologists, dieticians, podiatrists, homeopaths, naturopaths, practitioners of Chinese medicine and other forms of traditional and complementary medicine.

Community health and other

Community health and other refer to non-residential health services offered to patients and clients in an integrated and coordinated manner in a community setting, or the coordination of health services elsewhere in the community. Such services are provided by, or on behalf of, state and territory governments.

The term 'other' in 'community health and other' includes health spending that could not be allocated to a specific category. For example, providers of: substance abuse treatment; general health administration; or regional health services with no specified purpose.

Public health

Public health involves activities and services funded or delivered by state and territory health departments that aims to protect and promote the health of the whole population or specified population subgroups, rather than individuals. Examples of public health programs include communicable disease control, organised immunisation, food standards and hygiene, cancer screening, and prevention of hazardous and harmful drug use.

Benefit-paid pharmaceuticals

Benefit-paid pharmaceuticals are medications listed in the schedule of the PBS and the Repatriation Pharmaceutical Benefits Scheme (RPBS) for which pharmaceutical benefits have been paid or are payable (Box 2.5). They do not include listed pharmaceutical items where the full cost is met by the patient.

All other medications

These are pharmaceuticals for which no PBS or Repatriation Pharmaceutical Benefits Scheme (RPBS) benefit is paid. They include:

- pharmaceuticals listed in the PBS or RPBS, the total costs of which are equal to, or less than, the statutory patient contribution for the class of patient (under co-payment pharmaceuticals)
- pharmaceuticals dispensed through private prescriptions that do not fulfil the criteria for payment of benefit under the PBS
- over-the-counter medicines, including pharmacy-only medicines, aspirin, cough and cold medicines, vitamins and minerals, herbal and other complementary medicines, and medical non-durables such as condoms, adhesive and non-adhesive bandages.

Box 2.5: The Pharmaceutical Benefits Scheme

The PBS, established under the *National Health Act 1953* (NHA), is the Australian Government program which subsidises the cost of medicines. The PBS is managed by DoHAC and administered by Services Australia. The RPBS is subsidised by DVA.

PBS Section 85

Most general medicines are dispensed by community pharmacies and used by patients at home. These are known as Section 85 medicines because they are dispensed under section 85 of the NHA.

PBS Section 100

Section 100 provides alternative ways of providing a medicine when the usual supply through community pharmacies is unsuitable. The reasons include the cost of storage, requirements for particular controls over dispensing, the need for medical supervision or administration during treatment or constraints on patient access to community pharmacies (such as the supply of medicines to promote area Aboriginal Health Services).

There are several programs funded under this provision including the: Highly Specialised Drugs Program; Efficient Funding of Chemotherapy; Botulinum Toxin Program; Human Growth Hormone Program; IVF program; and the Opiate Dependence Treatment Program.

Paying for medications

Patients pay a co-payment towards the cost of each PBS medicine, with the Australian Government covering the remaining cost.

The PBS Safety Net scheme is intended to protect patients needing a large number of medicines in one year from excessive out-of-pocket costs. Individuals and families who spend an amount equal to their safety net threshold on co-payments receive further prescriptions free for that year.

Under co-payment is when medications are priced below the general patient co-payment.

Sometimes people have to pay more than the co-payment for prescriptions; this occurs if their particular brand of medicine listed on the PBS costs more than another brand of the same medicine.

The Highly Specialised Drugs Program

HSDs are subsidised through the PBS and administered under section 100 of the NHA. They are for the treatment of complex medical conditions that require ongoing specialised medical supervision. The HSD program is part of the PBS.

There are restrictions on where HSDs can be prescribed and supplied. In most cases, medical practitioners are required to undertake specific training or be affiliated with a specialised hospital unit to prescribe these medicines.

There are three components to the program: Public hospital (recorded as public hospital spending); Private hospital (recorded as private hospital spending); and Community access (recorded as benefit-paid pharmaceuticals). Community access arrangements which relate to HIV antiretroviral therapy, hepatitis B medicines and clozapine (maintenance therapy for schizophrenia treatment), can be dispensed from community pharmacies.

Sources: DoHAC 2021; Grove 2016.

Referred medical services

Referred medical services are those where the person has been referred by a GP or medical specialist. Typically, GPs refers patients to specialists, allied health professionals, diagnostic pathology and/or medical imaging providers.

In-hospital MBS services (except for dental) are mainly allocated to this area of spending, as it is not possible to identify whether the service occurred in a public or private hospital. The MBS benefit paid is attributed to Australian Government expenditure, while the fee charged minus benefit paid is attributed to individual spending. Spending by PHI funds on in-hospital medical services is allocated directly from the data supplied by Australian Prudential Regulation Authority (APRA), and the amount is offset from individual referred medical spending.

As a result of allocating in-hospital MBS services to referred medical services, spending by the Australian Government, individuals and PHI providers on public and private hospital services is under-estimated and the spending on referred medical services is over-estimated.

Prior to 2012–13, ‘Medical services’ had been used as an area of expenditure in HEA reporting, which included both referred and unreferred services. Since 2012–13, in order to differentiate between primary health care and non-primary health care, this area has been split into two separate areas: ‘Referred medical services’ and ‘Unreferred medical services’.

The majority of in-hospital MBS services are allocated to Referred medical services (except for items related to in-hospital dental services and to primary health care, such as GP and practice nurses in hospitals), with the funding contributed by the Australian Government, PHI providers and individual out-of-pocket costs.

Other services

Patient transport services

These are services or organisations primarily engaged in transporting patients, including the provision of health or medical care. They are often provided for a medical emergency, but not restricted to this. Vehicles used are generally equipped with lifesaving equipment and operated by medically trained personnel. Patient transport services include public ambulance services or flying doctor services, such as the Royal Flying Doctor Service and Care Flight.

Patient transport includes programs, such as patient transport vouchers or support programs to help isolated patients with travel to get specialised health care. Since 2003–04, these costs have been included in the operating costs of public hospitals.

Aids and appliances

These are medical goods used more than once for therapeutic purposes, such as glasses, hearing aids, wheelchairs, orthopaedic appliances, and prostheses fitted externally (rather than implanted surgically).

Administration

Administration relates to formulating and administering government and non-government health policy, and regulating and licensing providers of health services. Administrative services include only those that cannot be allocated to a particular health good or service. Such services might include maintaining an office for the chief medical officer, a departmental liaison officer in the office of the minister, or other agency-wide items for which it is not possible to derive appropriate or meaningful allocations to particular health programs.

Until 2008–09, departmental costs for some Australian Government regulators were reported under public health services. Regulators were the Therapeutic Goods Administration, Office of the Gene Technology Regulator, and National Industrial Chemicals Notification and Assessment Scheme. These are now reported as administration expenses.

Research

The Australian Government provides funding for research through:

- DoHAC programs for research
- DVA
- Capital consumption allocated to research
- University research

Some research is also funded by state and territory governments and non-government sources. This is research with a health socioeconomic objective undertaken in tertiary institutions, private non-profit organisations or government facilities. It excludes commercially oriented research funded by private business, the costs of which are assumed to be included in prices charged for the goods and services (for example, medications developed and/or supported by research activities).

Research spending data in this report mainly come from ABS Research and Experimental Development statistics, generally only available every second year. Where data were unavailable, estimates are calculated on the latest year available. Data on research spending from state and territory governments are also used.

Capital expenditure and depreciation

Capital expenditure is spending on large-scale fixed assets (for example, new buildings and equipment with a useful life extending over a number of years). Australian Government capital spending is often through grants and subsidies to other levels of government or to non-government organisations. In contrast, much of the resources of state and territory governments is apportioned to new and replacement capital for government service providers (for example, hospitals and community health facilities). Non-government capital spending is mainly on private hospitals.

In the ANHA, capital expenditure cannot be disaggregated by the area in which it has been spent. For example, it is not possible to determine the proportion of capital expenditure related to hospitals or primary health care.

Depreciation of capital is the amount of fixed capital used each year and is included in recurrent expenditure. It is sometimes referred to as capital consumption. Because depreciation is considered part recurrent expenditure in the ANHA, it is allocated and reported to different areas of health spending.

Prior to the *HEA 2007–08* (AIHW 2009) private capital depreciation was included as part of recurrent spending, while government capital depreciation was reported as part of total health expenditure but not recurrent expenditure.

The data for capital expenditure and capital depreciation are mainly sourced from the ABS's government finance statistics.

Deflators

A price index, also known as a deflator, is a measure of inflation. It shows the amount a price of good or service has changed over time relative to a base year. For example, the Consumer Price Index is a measure of the average change over time in the prices paid by households for a fixed basket of goods and services.

The deflator is used to derive constant price estimates. The AIHW uses annually re-weighted Laspeyres (base-period-weighted) chain price indexes and IPDs to calculate constant prices in the HEA. Chain price indexes are calculated at a detailed level and give a close approximation to measures of pure price change. IPDs are affected by changes in the composition of goods. Chain indexes, which give better measures of pure price change, are preferred to IPDs, but available indexes are not always ideal. In some cases, it has been necessary to use proxies for preferred indexes.

The reference, or base, year for deflators used in HEA report is the latest financial year (for example, in the HEA 2021–22, prices are calculated to 2021–22). As such, constant price estimates indicate what spending would have been had the base year price applied in all previous years. Therefore, any reported change in spending is a measure of changes in the volume of goods and services purchased, and not the cost of the goods and services.

In HEA reports, the measure used for general inflation is the IPD for Gross National Expenditure (GNE). GNE is a broad measure of the value of final expenditures on the goods and services purchased in the economy, including personal consumption, investment and purchases made by governments and foreigners, which includes imports but excludes exports. An IPD gives an indication of changes in the purchase price of these goods.

For comparative purposes, some analysis is also presented using the Gross Domestic Product (GDP) IPD. This measures change in the total value of goods and services Australian residents produce, including exports but excluding imports. For example, where exports form a major part of an economy's production, the GDP inflation figure can reflect international trends more than shifts in domestic pricing. In these cases, GNE may give a more accurate indication of inflation in domestic prices.

The total health price index is the AIHW's index of annual ratios of estimated total national health spending at current prices to estimated total national health spending at constant prices. Since the national total health price index is a measure of the change in average health prices from year to year at the national level, it can be used as a broad deflator for the health sector. The AIHW's method for deriving

constant price estimates also allows it to produce total health price indexes for each state and territory.

At the subsection level for the health sector, the AIHW uses indexes where the scope matches the particular health services being analysed, rather than broad-brush indexes covering all health services (Box 2.6). Most are specific to the type of spending to which they are applied. For hospitals, for example, the government final consumption expenditure (GFCE) hospitals and nursing homes deflator is used.

These deflators are sourced from the ABS:

- GFCE for hospitals and nursing homes
- professional health workers wage rate index
- HFCE for chemist goods
- gross fixed capital formation.

Box 2.6: Area of health spending, by type of deflator applied

Area of spending	Deflator applied
Public hospitals[(a)]/Public hospitals services[(a)]	GFCE hospitals and nursing homes
Private hospitals	GFCE hospitals and nursing homes
Patient transport services	GFCE hospitals and nursing homes
Medical services	MBS medical services fees charged
Dental services	Dental services
Other health practitioners	Other health practitioners
Community health and other[(b)]	Professional health workers wage rate index
Public health	GFCE hospitals and nursing homes
Benefit-paid pharmaceuticals	PBS pharmaceuticals
All other medications	HFCE on chemist goods
Aids and appliances	Aids and appliances
Administration	Professional health workers wage rate index
Research	Professional health workers wage rate index
Capital expenditure	Gross fixed capital formation
Medical expenses tax rebate	Professional health workers wage rate index

(a) Public hospital services exclude certain services provided in hospitals, and can include services provided off site, such as hospital in the home and dialysis.

(b) 'Other' includes recurrent health spending that could not be allocated to a specific area of spending. For example, spending by substance abuse treatment centres, providers of general health administration, or providers of regional health services not further defined.

Government funding sourcesThe AIHW derives the chain price index from the MBS medical services fees charged and the IPD for PBS pharmaceuticals from data provided by DoHAC. The IPDs for dental services, other health practitioners, and aids and appliances were derived from ABS and APRA data.

Overview of data sources and methodology

The HED, where the AIHW health expenditure data are collated and stored, is compiled each financial year. However, it takes approximately 15 to 18 months after the end of the reference year to receive, process, check and analyse the data, and release the HEA report.

Allocation of expenditure

The HED is structured to reflect the flow of funds in the health system (Figure 32), each column representing a funding source and the rows, the areas of expenditure (Table T1).

Derivation of expenditure estimates are based around the source of funding approach, whereby offsets are made to avoid double counting and to reflect the original source of funding.

This structure is reflected further in the estimates reported in the HEA, which presents health spending firstly by source of funds and secondly by area of expenditure.

State and territory level data

Data are disaggregated and reported at the state/territory level. Where the state/territory level data are not available in the source data, the expenditure estimates are allocated to the states and territories using allocation factors such as population or medical staffing proportions.

More detailed levels of geographical and demographical data (such as Statistical Area 3, data by age group, and data by socio-economic group) are not available in the HED. Such level of details might be available in AIHW's Disease expenditure reports.

Offsets

Offsetting is the mechanism by which an adjustment is made for potential double counting of expenditure. By applying an offset, account is taken of circumstances where the same funds are spent more than once due to the way they flow in the health system. In these instances, a decision is required about which source the expenditure will be counted against. In the ANHA the source of funds approach is used to allocate expenditure to where the funds originated. The offsets are explained in detail throughout this chapter.

An example of an offset is that, as state and territory governments receive funding from the Australian Government, such as NHR funding and health-related NPPs, the spending is counted as components of spending by the Australian Government. The corresponding amounts are then deducted from state and territory governments' gross expenditure to remove any double counting. Revenue that state and territory governments received from other sources (such as from DVA or non-government entities) are accounted for in a similar way.

Table T1: Health expenditure database structure and cell addresses, by source of funding (columns) by area of expenditure (rows)

	Australian Government						**State and territory governments**	**Non-government funding sources**				
	A Department of Veterans' Affairs (DVA)	B Australian Government funding of states and territories	C PHI rebate claimed through PHI providers	D Department of Health and Aged Care (DoHAC)	E Other Australian Government	M PHI rebate claimed through tax	F State and territory governments (including local government)	G PHI providers	H Individuals	I Other private	J Workers' compensation insurance providers	K CTPI providers
01 Public (acute care) hospitals	A01	B01	C01	D01	E01	M01	F01	G01	H01	I01	J01	K01
04 Private (acute care) hospitals	A04	B04	C04	D04	E04	M04	F04	G04	H04	I04	J04	K04
05 Acute care hospitals (not elsewhere classified)	A05	B05	C05	D05	E05	M05	F05	G05	H05	I05	J05	K05
06 Public psychiatric hospitals	A06	B06	C06	D06	E06	M06	F06	G06	H06	I06	J06	K06
11 High-level residential care	A11	B11	C11	D11	E11	M11	F11	G11	H11	I11	J11	K11
12 Patient transport services	A12	B12	C12	D12	E12	M12	F12	G12	H12	I12	J12	K12
13 Other institutional health services (not elsewhere classified)	A13	B13	C13	D13	E13	M13	F13	G13	H13	I13	J13	K13
14 Referred medical services	A14	B14	C14	D14	E14	M14	F14	G14	H14	I14	J14	K14
15 Dental services	A15	B15	C15	D15	E15	M15	F15	G15	H15	I15	J15	K15
16 Other health practitioners	A16	B16	C16	D16	E16	M16	F16	G16	H16	I16	J16	K16
20 Community health	A20	B20	C20	D20	E20	M20	F20	G20	H20	I20	J20	K20

21 Benefit paid pharmaceuticals	A21	B21	C21	D21	E21	M21	F21	G21	H21	I21	J21	K21
22 All other medications	A22	B22	C22	D22	E22	M22	F22	G22	H22	I22	J22	K22
24 Aids and appliances	A24	B24	C24	D24	E24	M24	F24	G24	H24	I24	J24	K24
25 Other non-institutional (not elsewhere classified)	A25	B25	C25	D25	E25	M25	F25	G25	H25	I25	J25	K25
27 Public health	A27	B27	C27	D27	E27	M27	F27	G27	H27	I27	J27	K27
28 Hospital insurance administration	A28	B28	C28	D28	E28	M28	F28	G28	H28	I28	J28	K28
29 Medical insurance administration	A29	B29	C29	D29	E29	M29	F29	G29	H29	I29	J29	K29
30 Other administration	A30	B30	C30	D30	E30	M30	F30	G30	H30	I30	J30	K30
31 University based research	A31	B31	C31	D31	E31	M31	F31	G31	H31	I31	J31	K31
32 Other research	A32	B32	C32	D32	E32	M32	F32	G32	H32	I32	J32	K32
34 Education of health professionals	A34	B34	C34	D34	E34	M34	F34	G34	H34	I34	J34	K34
36 Capital expenditure	A36	B36	C36	D36	E36	M36	F36	G36	H36	I36	J36	K36
37 Medical expenses tax rebate	A37	B37	C37	D37	E37	M37	F37	G37	H37	I37	J37	K37
40 Unreferred medical services	A40	B40	C40	D40	E40	M40	F40	G40	H40	I40	J40	K40
68, 69, 99 Welfare expenditure	A68–99	B68–99	C68–99	D68–99	E68–99	M68–99	F68–99	G68–99	H68–99	I68–99	J68–99	K68–99

Notes:

High-level residential care (row 11) and Education of health professionals (row 34) are not currently considered to be in the scope of health expenditure. Rows 68, 69 and 99 are set up to take welfare expenditure. Expenditure for these categories is not included in the ANHA.

Table T1Rows 01, 05 and 06 are counted as public hospital services; rows 28, 29 and 30 combine to administration; while rows 31 and 32 are counted as research.

Overview of data sources and methodology

On this page:

The Australian Government

The Australian Government total health spending includes spending:

- by DVA (column A)
- by grants to states and territories, through NHR funding and NPPs (column B), including HSDs in public hospitals
- on PHI premium rebate claimed through providers (column C) and through taxes (column M)
- by DoHAC, including spending on MBS and PBS programs (column D)
- by other Australian Government agencies, such as spending on capital expenditure, capital depreciation, health research and the net medical expenses tax rebate (which had phased out by the end of 2018–19) (column E). Since 2019–20, spending by the Department of Defence is also included.

Column A – Department of Veterans' Affairs

Expenditure components	Offsets	Notes
• DVA health spending data (rows 01, 04, 06, 12, 14, 15, 16, 24, 30, 32, 40) • RPBS data on benefits payments (row 21)	None	• DVA Public hospitals (rows 01, 06) is offset against State and territory governments (column F) • DVA Private hospitals (row 04) is offset against Individuals (column H) • DVA Other research (row 32) is offset against Other Australian Government (column E)

Expenditure components

The Australian Government funds DVA by making payments through DVA for health services to eligible veterans and their dependents.

Annual expenditure statistics for estimating spending by DVA are sourced from three tables:

- 'MRCA and SRCA' (which are related to payments for health care under the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988*, *Military Rehabilitation and Compensation Act2004* and *Safety Rehabilitation Compensation Act 1988*)
- 'Program benefits' that qualify under DVA National Treatment Account
- RPBS.

The payments of health goods and services from 'MRCA and SRCA' and 'Program benefits' are mapped to areas of spending:

- Public hospitals (row 01)
- Private hospitals (row 04)
- Public psychiatric hospitals (row 06)
- Patient transport services (row 12)
- Referred medical services (row 14)
- Dental services (row 15)
- Other health practitioners (row 16)
- Benefit paid pharmaceuticals (row 21)
- Aid and appliances (row 24)
- Other administration (row 30)
- Other research (row 32)
- Unreferred medical services (row 40).

Payments for Pharmaceutical Services in 'Program Benefits' is apportioned to states and territories using proportions derived from the RPBS.

DVA's spending on Residential Nursing Home is allocated to row 11 (High-level residential care) and spending on Community Nursing is allocated to row 68 (Welfare expenditure) – these are not currently included in the ANHA.

Offsets

There are no offsets for column A.

Notes

DVA's spending on:

- Public hospitals are offset against State and territory governments (column F) to derive State and territory own spending on Public hospitals.
- Private hospitals are offset against Individuals (column H), which includes total patient revenue from private hospitals obtained from the PHDB.
- Other research is offset against Other Australian Government (column E) as these amounts are captured in ABS Research and Experimental Development statistics, used to estimate the total spending by the Australian Government on health research.

Also note that DVA changed their reporting system of health expenditure since 2020–21 which have some impacts on the time series of health spending in this report. Therefore, caution should be exercised when comparing results between years for any area of expenditure.

Column B – Australian Government funding of States and territories

Expenditure components	Offsets	Notes
• NHR funding for Public hospitals (row 01): data from Treasury Final Budget Outcome and NHFB • NHR funding for Public health (row 27): data from Treasury Final Budget Outcome and NHFB • Other NHR funding, including NPCR funding (rows 01, 04, 12, 20, 27, 36) • NPPs on various areas (rows 01, 14, 15, 20, 27, 30, 32, 36, 40, etc.): data from Treasury Final Budget Outcome • PBS Section 100 programs in Public hospitals (row 01): data from PBS (Section 100)	None	• NHR, NPPs are offset against State and territory governments (column F) in row 01 and other relevant rows (except for capital grants in row 36) • PBS Section 100 programs are offset against State and territory governments (column F) (row 01) • Other research (row 32) is offset against Other Australian Government (column E) • Capital grants (row 36) are offset against capital expenditure by Other Australian Government (column E)

Expenditure components

The Australian Government contributes to funding of health services to the states and territories through the NHRA. NHR funding is primarily directed to spending on the public hospital systems managed and administered by the states and territories. Health-related payments are also made as NPPs for specific projects or outcomes.

The data used in estimating the Australian Government funding of states and territories are sourced from:

- NHR funding and NPPs from Table 3.13 of the Treasury Final Budget Outcome, with updates from the NHFB.
- PBS Section 100 programs from DoHAC PBS (Section 100).

These data are provided at the state/territory level.

NHR funding is assigned to Public hospitals (row 01) and Public health (row 27). Payments under NPPs are mapped to the relevant areas of spending, including:

- Public hospitals (row 01)
- Referred medical services (row 14)
- Dental services (row 15)
- Community health (row 20)
- Public health (row 27)
- Other administration (row 30)
- Research (row 32)
- Capital expenditure (row 36)
- Unreferred medical services (row 40).

Since 2019–20, the NHR funding has been including the Australian Government contribution in the National Partnership on COVID-19 Response (NPCR). Data for the NPCR entitlements are obtained from the NHFB and are allocated to public hospitals (row 01), private hospitals (row 04), community health (row 20), public health (row 27), patient transports (row 12), and capital expenditure (row 36). Personal protective equipment (subject to 2018–19 baseline) spending is allocated to rows 01, 04, 12, 20, and 27 using state and territory's reported gross expenditure spending on those areas.

Offsets

There are no offsets for column B.

Notes

To derive state and territory own expenditure, the Australian Government funding of states and territories is offset against State and territory governments' gross expenditure (column F) in relevant areas of spending, except for capital expenditure.

Capital expenditure and other research are offset against the relevant areas by Other Australian Government (column E), as column E already includes the total spending by the Australian Government on health research and capital expenditure.

Column C – Private health insurance rebate claimed through private health insurance providers

Expenditure components	Offsets	Notes
PHI premium rebate claimed through providers: data from DoHAC program cost centre expenditure. Total rebate is allocated to various areas (rows 01, 04, 12, 14, 15, 16, 20, 22, 24, 28) based on PHI provider benefit payments (data from APRA)	None	PHI premium rebate is offset against PHI providers (column G) in relevant areas

Expenditure components

The Australian Government subsidises the cost of PHI by paying a rebate on the premiums paid by individuals for PHI. It is regarded as an indirect subsidy of all types of health services through PHI. The rebate can be paid directly to PHI providers (column C) or through the tax system (column M) (Box 2.2).

The data used in processing PHI rebates claimed through PHI providers are sourced from the relevant DoHAC program cost centre expenditure. This amount is allocated to areas of expenditure based on the proportion of benefit payments in each area by PHI providers (Box 3.1), obtained from APRA data:

- Public hospitals (rows 01)
- Private hospitals (row 04)
- Patient transport services (row 12)
- Referred medical services (row 14)
- Dental services (row 15)
- Other health practitioners (row 16)
- Community health (row 20)
- All other medications (row 22)
- Aids and appliances (row 24)
- Hospital insurance Administration (row 28)

Box 3.1: Apportioning private health insurance rebates to areas of health expenditure

Rebate amounts are allocated to areas of expenditure based on the proportion of benefit payments in each area by PHI providers.

However, not all revenue collected by PHI providers is spent on health. Data from APRA are used to compute the proportion of total PHI provider revenue paid out as health benefits and spent as health administration. This proportion is applied to calculate the total rebate amount spent for health purposes. As the result, the estimate of health spending reported in HEA is an estimate of the rebate paid out as benefits. It is therefore smaller than the total rebate paid to individuals to reduce premiums.

For example, in 2018–19, data from APRA showed that 94.3% of total PHI provider revenue was spent on health (including paid out as health benefits to members and spent on administration). As the rebate is treated as a revenue source for PHI providers, only 94.3% of the total rebate is counted as health expenditure in the same year.

More detail on the processing of these data are described in Column G – PHI providers.

Offsets

There are no offsets for column C.

Notes

PHI premium rebate amounts paid by the Australian Government are offset against PHI providers (column G) in the relevant areas of spending. Column G calculates the gross health expenditure funded by PHI providers, therefore subsidies from the Australian Government (through PHI providers and through taxes) are subtracted to derive PHI providers' own health spending.

Column D – Department of Health and Aged Care (DoHAC)

Expenditure components	Offsets	Notes

Spending administered by DoHAC on health and medical services (excluding MBS) in various areas (rows 01 to 40): data from the DoHAC program cost centres Benefit payments for medical services covered by MBS (rows 14, 15, 16, 40): data from MBS. Benefit payments for pharmaceuticals under the PBS (Section 85) (row 21) PBS Section 100 programs in Private hospitals (row 04) and community (row 21) Departmental expenses of DoHAC and Services Australia allocated to Other administration (row 30)	None	Health research (rows 31, 32) and Capital expenditure (row 36) spending is offset against Other Australian Government (column E)

Expenditure components

The Australian Government contributes significantly to health funding through programs and payments administered through DoHAC. These include:

- payments of benefits for medical services covered by MBS
- payments of benefits for pharmaceuticals under the PBS
- direct spending on health and medical services, excluding MBS benefit payments from DoHAC program cost centres
- departmental expenses by DoHAC and Services Australia administration spending for health purpose.

Program cost centres (except the cost centre for PHI rebates claimed through PHI providers, as mentioned in column C) are mapped to the relevant areas of expenditure based on the main purpose of the service. The cost centres are checked thoroughly annually with DoHAC to ensure new items are included and mapped accordingly. State-specific cost centres are allocated to the relevant state or territory. For cost centres that are not state-specific, factors such as population or staff number proportions are used to allocate expenditure at the state/territory level.

These cost centres are assigned to the following areas of expenditure:

- Hospitals: Public hospitals (rows 01, 05, 06), Private hospitals (row 04)
- Primary health care: Dental services (row 15), Other health practitioners (row 16), Community health (row 20), Benefit paid pharmaceuticals (row 21), All other medications (row 22), Public health (row 27) and Unreferred medical services (row 40)
- Referred medical services (row 14)
- Other services: Patient transport services (row 12), Aids and appliances (row 24), Hospital insurance administration (row 28), Medical insurance administration (row 29) and Other administration (row 30)
- Research: University based research (row 31) and Other research (row 32)
- Capital expenditure (row 36).

Payments of benefits for medical services on the MBS are used to compute the health spending for: Referred medical services (row 14); Dental services (row 15); Other health practitioners (row 16), and Unreferred medical services (row 40).

Note that, since 2012–13, in-hospital MBS services have been allocated to row 14 (the majority) and row 40 (a small amount of PHC provided in hospitals) due to the unavailability of identifying whether a particular MBS service is provided in a public or private hospital.

As DoHAC spending on aged care, sports and health workforce is not currently in the scope of the ANHA, a proportion of total spending is calculated to estimate the health component of the administrative and departmental expenses of DoHAC. This proportion is also used for the departmental expenses of Services Australia. The results are allocated to Other administration (row 30).

Offsets

There are no offsets for column D.

Notes

Spending for research (rows 31, 32) and Capital expenditure (row 36) is offset against Other Australian Government (column E).

Column E – Other Australian Government

Components	Offsets	Notes

• Medical expenses tax rebate (row 37): data from Treasury–Tax Benchmarks and Variations Statement • Australian Government expenditure on health research (rows 31, 32): data from ABS Research and Experimental Development statistics (health) • Australian Government capital expenditure (row 36): data from ABS Government GFCF • Australian Government capital depreciation: data from ABS Capital Consumption (ETF 1231) (various rows 01 to 40) using proportions calculated from DoHAC's cost centre data in Column D • Department of Defence health spending (various rows 01 to 40); reported since 2019–20	• Health research (rows 31, 32) and Capital expenditure (row 36) from DVA, DoHAC's cost centres, and Australian Government grants to states and territories	• Medical expenses tax rebate (row 37) is offset against Individuals (column H)

Expenditure components

This column includes other spending on health by the Australian Government (except DVA, DoHAC, grants to states and territories and PHI rebates). The data used in estimating this are sourced from:

- Medical expenses tax offset from Treasury–Tax Benchmarks and Variations Statement. The Australian Government contributes to funding for health through the medical expenses tax rebate, available to individuals to claim through the taxation system if they have out-of-pocket medical expenses over a specified amount. As of 01 July 2019, the rebate was no longer obtainable, with a small amount of late processing in 2019–20.
- Expenditure by the Australian Government on research from ABS Research and Experimental Development statistics, is generally only available every second year. The ABS research surveys used are:
- 8111.0 Research and Experimental Development, Higher Education Organisations, Australia. Tables: 81110do003 (by source of funds) and 8110do006 (by socio-economic objective). Data are available on a state/territory basis.
- 8109.0 Research and Experimental Development, Government and Private Non-profit Organisations, Australia. Tables: 81090do003 (Government expenditure) and 81090do007 (Private non-profit expenditure). Data are allocated to state/territory level using population proportions.

- Australian Government capital expenditure from ABS Government Gross Fixed Capital Formation (GFCF).
- Australian Government capital depreciation from ABS capital consumption (Economic type framework (ETF) 1231), with depreciation allocated to various areas (rows 1 to 40) using proportions calculated from DoHAC's cost centre data (column D).

Spending on health research funded by the Australian Government is derived using:

- research with a health socioeconomic objective only from the ABS research surveys
- the Higher Education Organisations survey provides estimates for University based research (row 31)
- the Government and Private Non-profit Organisations survey provides estimates for Other research (row 32).

Research funded by State and territory governments and local governments is included in column F, while research funded by the private sector is included in column I (Other private).

NHMRC grants are included as other Australian Government expenditure but are offset against itself since the grants have been accounted for in the University based research from the Higher Education Organisations survey.

Capital expenditure (row 36) by the Australian Government obtained from ABS Government GFCF is available at a national level only; these estimates are allocated to states and territories based on the proportion of health and medical staff in each jurisdiction.

The ABS data on depreciation of fixed assets (ETF 1231) for the Australian Government are allocated to the relevant area of spending and the state/territory level by using proportions calculated from cost centre data (processed in column D).

Since 2019–20, health expenditure by Australian Department of Defence (rows 01 to 40) has been added to the HED in column E.

Offsets

The ABS research surveys and ABS Government GFCF provide comprehensive estimates for Australian Government expenses relating to health research (rows 31, 32). Therefore, health research spending funded by DVA (column A), grants to states and territories (column B), and DoHAC (column D) are offset in column E to avoid double counting. Similarly, spending from DoHAC's cost centres and Australian Government grants to states and territories on capital expenditure (row 36) are also offset in this column.

Notes

Medical expenses tax rebate (row 37) is treated as a subsidy by the Australian Government to Individuals. It is offset against Individuals health spending in column H. This rebate was phased out after the end of 2018–19.

Column M – Private health insurance rebate claimed through tax

Components	Offsets	Notes
PHI premium rebates through tax: data from the ATO Annual report. Total rebate is allocated to various areas (rows 01, 04, 12, 14, 15, 16, 20, 22, 24, 28) based on PHI provider benefit payments (data from APRA)	None	PHI premium rebates are offset against the PHI providers (column G) in relevant areas

Expenditure components

The Australian Government subsidises the cost of PHI by paying a rebate on the premiums individuals pay for this insurance. It is regarded as an indirect subsidy of all types of health services through PHI. The rebate can be paid through the tax system (column M) or directly to PHI providers, which reduces premiums (column C) (Box 2.2). Where the premium rebate is claimed through tax, PHI members pay the full premium and claim the rebate at the end of the financial year.

Data for the total PHI premium rebates claimed through tax are sourced from:

- ATO Annual report.

The rebate amounts are allocated to areas of expenditure based on the proportion of benefit payments in each area by PHI providers (Box 3.1), obtained from APRA data:

- Public hospitals (rows 01)
- Private hospitals (row 04)
- Patient transport services (row 12)
- Referred medical services (row 14)
- Dental services (row 15)
- Other health practitioners (row 16)
- Community health (row 20)
- All other medications (row 22)
- Aids and appliances (row 24)
- Hospital insurance Administration (row 28)

More detail on the processing of these data are described in Column G – PHI providers.

Offsets

There are no offsets for column M.

Notes

The PHI premium rebate amounts paid by the Australian Government are offset against PHI providers (column G) in the relevant areas of spending. Column G calculates the gross health expenditure funded by PHI providers, therefore subsidies by the Australian Government (through taxes as well as through funds) are subtracted to derive PHI providers' own health spending.

Overview of data sources and methodology

Column F – State and territory governments

Expenditure components	Offsets	Notes
• Gross expenditure (rows 01, 04, 05, 06, 12, 15, 16, 20, 27, 30, 32): data from GHE NMDS 'Gross expenditure' provided by states and territories • State and territory capital consumption (depreciation): data from ABS capital consumption (prior to 2019–20) or state and territory depreciation (since 2019–20) are allocated to various areas using proportions calculated from GHE NMDS 'Depreciation' • State and territory Capital expenditure (row 36): data from ABS Government GFCF • Expenditure funded by state and territory governments on health research (rows 31, 32): data from ABS Research and Experimental Development statistics	• Revenue and Depreciation: data from GHE NMDS 'Revenue' and 'Depreciation' • Revenue from DVA for Public hospitals (row 01): data from DVA • Revenue from PHI providers for public hospital services (row 01) and the ambulance levy (row 12): data from APRA • NHR funding for Public hospitals (row 01) and Public health (row 27): data from Treasury Final Budget Outcome and NHFB • NPCR funding (rows 01, 04, 12, 20, 27): data from NHFB • NPPs on various areas (various rows 01 to 40): data from Treasury Final Budget Outcome. • PBS Section 100 programs in Public hospitals (row 01) • Revenue from workers' compensation insurance and CTPI for public hospital services (row 01)	None

Expenditure components

State and territory governments manage and administer the public hospital system as well as many other health goods and services. These goods and services are financed by a combination of their own funding (column F), as well as funds from the Australian Government and non-government sources.

The major sources of data on spending on most health activities by state and territory governments are supplied through the GHE NMDS, which includes 3 main tables:

- 'Revenue' – all revenue received from DVA and any payments from government departments in other states or territories in relation to cross-border charging, but excluding Australian Government funding such as NHR funding. This table is categorised by revenue source and organisation type.
- 'Gross expenditure' – wages, salaries and supplements, employer superannuation contributions, workers' compensation premiums and payouts, purchases of goods and services and capital depreciation for all health services. This table is categorised by organisation type and function.
- 'Depreciation' – consumption of fixed capital for all health services. This table is categorised by organisation type and function.

Data from GHE NMDS 'Gross expenditure' for each state and territory are mapped with areas of expenditure based on the organisation type, and assigned to the following areas:

- Public hospitals (rows 01, 05 and 06)
- Private hospitals (row 04)
- Patient transport services (row 12)
- Dental services (row 15)
- Other health practitioners (row 16)
- Community health (row 20)
- Public health (row 27)
- Administration (row 30)
- Other research (row 32).

GHE NMDS 'Gross expenditure' includes capital depreciation. Prior to 2019–20, depreciation of capital data from ABS statistics were used instead of the figures from GHE NMDS 'Depreciation'. The ABS depreciation was allocated on the basis of the depreciation proportion by organisation function from the GHE NMDS. Since 2019–20, since the ABS depreciation data did not take into account the accounting standard changes related to leases (AASB, 2016), depreciation data in Table 4 GHE NMDS are used instead.

State and territory capital expenditure (row 36, data from ABS Government GFCF) and expenditure funded by state and territory governments on health research (rows 31 and 32, data from ABS Research and Experimental Development statistics) are added to complete the gross expenditure components.

Offsets

Revenue computed for each area of spending are offset against the respective gross expenditure in each area. Data for revenue in GHE NMDS 'Gross expenditure' are not collected by function codes, therefore revenue data are allocated across functions (areas of expenditure) based on the proportions of gross expenditure in each organisation type. This results in a distribution of revenue for each area of spending.

Revenue from the Australian Government and non-government sources are offset against state and territory spending, including:

- revenue from DVA for public hospitals (row 01): data from DVA (processed in column A)
- revenue from PHI for public hospital services (row 01) and ambulance levy (row 12): data from APRA (processed in column G)
- NHR funding for public hospitals (row 01) and public health (row 27): data from Treasury Final Budget Outcome and NHFB.
- Since 2021–22, the NHR funding on public hospitals (row 01), private hospitals (row 04), community health (row 20), public health (row 27), and patient transports (row 12). Note that capital expenditure is not reported in the GHE NMDS, the NPCR funding allocated in row 36 is not offset in column F. More details are provided in column B.
- NPPs on various areas (various rows from 01 to 40): data from Treasury Final Budget Outcome.
- PBS Section 100 programs in Public hospitals: row 01
- revenue from workers' compensation insurance and CTPI for public hospital services (row 01).

Notes

There are no offsets from states and territories (column F) to other expenditure sources (other columns). However, revenues from specific sources (GHE NMDS 'Revenue') are used to determine the health expenditure in relevant columns, such as:

- revenue from Workers' compensation insurance is treated as column J expenditure
- revenue from CTPI is treated as column K expenditure
- revenue from Private households (Self-funded/out-of-pocket expenditure) is treated as column H expenditure
- revenue from Other private sector is treated as column I expenditure.

Overview of data sources and methodology

On this page:

The non-government total health spending includes spending:

- by PHI providers (column G)
- by Individuals (column H)
- by Other private entities (column I)
- by Workers' compensation insurance providers (column J)
- by CTPI providers (column K)

Column G – Private health insurance providers

Expenditure components	Offsets	Notes
• PHI provider gross health expenditure (benefits paid and administration) (various rows 01 to 28): data from APRA	• The Australian Government rebates for private health insurance premium claimed through providers (processed in column C) and tax (processed in column M) (various rows 01 to 28)	• PHI provider gross health expenditure in rows 04, 14, 15, 16, 22, 24 is offset against Individuals (column H) • PHI provider gross expenditure in Public hospitals (row 01) is offset against State and territory governments (column F) • PHI provider gross expenditure for the ambulance levy (row 12) is offset against State and territory governments (column F) (NSW and ACT only)

Expenditure components

PHI providers help finance certain health goods and services. Health spending by PHI providers are the gross fund benefits paid to health providers and administration spending. Expenditure estimates are equal to gross health spending minus the PHI premium rebates (claimed through PHI providers and tax; processed in columns C and M, respectively).

APRA provides input data for these estimates, on a state and territory basis, from the following:

- PHI Membership and Benefits
- PHI Prosthesis Report
- Operations of Private Health Insurers Annual Report data.

Gross health spending by the PHI providers is mapped to the following areas of expenditure:

- Public hospitals (row 01)
- Private hospitals (row 04)
- Patient transport services (row 12)
- Referred medical services (row 14) (as discussed in column D above, this is related to in-hospital MBS services where PHI shares the gap payment after the Australian Government benefit is paid)
- Dental services (row 15)
- Other health practitioners (row 16)
- Community health (row 20)
- All other medications (row 22)
- Aids and appliances (row 24)

The ambulance levy for NSW and ACT are assigned as Patient transport services (row 12). Because many NSW residents in areas close to the ACT can use the hospital services in ACT, the levy amount provided by APRA in 'State levies' is adjusted proportionally using ambulance levy figures from NSW Treasury and ACT Treasury.

Total administrative expenses are assigned to Hospital insurance administration (row 28).

Offsets

The Australian Government rebates for PHI premiums claimed through PHI providers and tax (columns C and M, respectively) are treated as subsidies to PHI providers, therefore these are deducted from gross expenditure by PHI providers.

Notes

The PHI provider gross health expenditure (including all subsidies) in rows 04, 14, 15, 16, 22, 24 is offset against Individuals (column H).

The spending amounts on Public hospitals (row 01) and Ambulance levy (row 12, for NSW and ACT) are offset against the relevant state and territory governments (column F).

Column H – Individuals

Expenditure components	Offsets	Notes
• Private hospital patient revenue (row 04): data from PHDB and ABS PHEC • Patient contribution for medical services covered by MBS (rows 14, 15, 16, 40): data from MBS • Patient contribution for pharmaceuticals from the PBS Section 85 and RPBS (rows 21, 22): data from PBS and RPBS • Payments for over-the-counter pharmaceuticals in pharmacies and supermarkets (row 22): data from IRI • Payments for private, non-benefit pharmaceuticals (row 22): data estimated using Pharmacy Guild of Australia and historical data • Individual health expenditure for Dental services (row 15), Other health practitioners (row 16), Aids and appliances (row 24): estimated using historical data and growths of PHI fee charges and coverage • Revenue received by state and territory health organisations from individuals or households (in various rows from 01 to 32): data from GHE NMDS 'Revenue' table	• PHI gross expenditure (rows 04, 14, 15, 16, 22, 24): data from APRA (processed in column G) • DVA funded Private hospitals payments (row 04) (processed in column A) • Benefit payments by injury insurance providers (rows 04, 22, 24): data from CTPI and workers compensation insurance regulatory authorities and Comcare (processed in columns J and K) • Medical expenses tax rebate (row 37): data from Treasury–Tax Benchmarks and Variations Statement (processed in column E)	None

Expenditure components

Individuals fund health goods and services through out-of-pocket costs. This includes co-payment for government-subsidised goods and services, co-payment for the cost of health goods and services with third party payers and meeting the full cost of goods and services (see Individuals in Concepts and definitions).

The data used in estimating these costs are sourced from:

- Private hospital patient revenue (row 04) from PHDB and ABS PHEC.
- Out-of-pocket contributions for health services for Referred medical services (row 14, including in-hospital and out-of-hospital MBS), Dental services (row 15), Other health practitioners (row 16) and Medical services (unreferred) (row 40) from MBS. The contribution by individuals is derived by subtracting the benefits paid from the fees charged.
- Individual contributions for medications covered by PBS Section 85 and RPBS (rows 21 and 22) from PBS and RPBS, respectively. For prescriptions that cost above the co-payment, individual contributions are assigned to Benefit-paid pharmaceuticals (row 21). For prescriptions which are priced below the co-payment, individual costs are assigned to All other medications (row 22).
- Data about payments for medications purchased in pharmacies and supermarkets (row 22) are obtained from IRI. State and territory level spending is derived using proportions obtained from historical ABS HFCE.
- Payments for prescriptions for which no benefit is payable are estimated using The Pharmacy Guild of Australia and historical data and allocated to All other medications (row 22).
- Expenditure on Dental services (row 15), Other health practitioners (row 16), Aids and appliances (row 24) is estimated using historical data and the growth rate of PHI fees charged and the growth of PHI member coverage obtained from APRA.
- revenue from individuals received by state and territory health organisations (in various rows (from 01 to 32) is from the GHE NMDS 'Revenue'. More details on the allocation of revenue to areas of expenditure in GHE NMDS are described in the processing of column F (state and territory governments).

Offsets

- PHI gross expenditure (in rows 04, 14, 15, 16, 22, 24) (processed in column G) is offset from the total gap payment (after the government benefits) in the relevant area of spending.
- Private hospital payments (row 04) by individuals that are funded by DVA (processed in column A) are offset as DVA subsidises costs to eligible veterans and families.

- Benefit payments by injury insurance providers (rows 04, 22, 24) are offset against individual costs (processed in columns J and K), as individuals are reimbursed these costs.
- Medical expenses tax rebate (row 37), which is from Treasury–Tax Benchmarks and Variations Statement (processed in column E) to account for reimbursement of individual costs through the taxation system. This item phased out after 2018–19, though a small amount appears in 2021–22 data (late claims and processing).

Notes

There are no further notes for column H.

Column J – Workers' compensation insurance providers

Expenditure components	Offsets	Notes
• Health payments by workers' compensation insurance providers (rows 01, 04, 12, 14, 15, 16, 20, 22, 24, 40): data from state and territory workers' compensation regulators and Comcare • Revenue received by state and territory health organisations from workers' compensation insurance providers (rows 01, 06, 12, 15, 20, 27, 30, 32): data from GHE NMDS 'Revenue' (for some jurisdictions)	None	• Public hospital spending (row 01) is offset against State and territory governments (column F) for some jurisdictions • Private hospitals (row 04), All other medication (row 22) and Aids and Appliances (row 24) are offset against Individuals (column H)

Expenditure components

Workers' compensation is a form of compulsory insurance payment to employees if they are injured at work or become sick due to their work (see Workers compensation insurance workers).

Data on health expenditure by workers' compensation insurance providers are obtained from the workers' compensation insurance regulatory authority in each state and territory (Box 2.3) and Comcare.

Data on benefits paid by Vic, SA, ACT, NT and Comcare are mapped to the following areas of expenditure:

- Public hospitals (row 01)
- Private hospitals (row 04)
- Patient transport services (row 12)
- Referred medical services (row 14)
- Dental services (row 15)
- Other health practitioners (row 16)
- Community health (row 20)
- All other medications (row 22)
- Aids and Appliances (row 24)
- Unreferred medical services (row 40).

Data on benefits paid are not provided for several health service categories for NSW, Qld, WA and Tas. For these states, data are apportioned based on benefits paid to each area of expenditure in Vic, SA and through Comcare.

For some jurisdictions, revenues from workers' compensation insurance providers reported in GHE NMDS 'Revenue' are also included in workers' compensation insurance expenditure (in rows from 01 to 32).

Offsets

There are no offsets for column J.

Notes

The amounts funded by workers' compensation insurance for Private hospitals (row 04), All other medication (row 22), Aids and Appliances (row 24) are offset against Individuals (column H) in the respective areas of expenditure.

The amounts of Public hospitals (row 01) funded by Workers' compensation insurance are offset against State and territory governments (column F) for some jurisdictions.

Column K – Compulsory third party motor vehicle insurance providers

Expenditure components	Offsets	Notes

• Health payments by CTPI providers (rows 01, 04, 12, 14, 15, 16, 20, 22, 24, 40): data from state and territory CTPI regulators • Revenue received by state and territory health organisations from CTPI providers (rows 01, 06, 12, 15, 20, 27, 30, 32): data from GHE NMDS 'Revenue' (for some jurisdictions)	None	• Public hospital spending (row 01) is offset against State and territory governments (column F) for some jurisdictions • Private hospitals (row 04), All other medication (row 22), Aids and Appliances (row 24) are offset against Individuals (column H)

Expenditure components

CTPI provides compensation for anyone injured or killed in a motor vehicle accident (see Compulsory third party motor vehicle insurance providers).

Data on expenditure by CTPI providers are obtained from the CTPI regulatory authority in each state and territory (Box 2.4). Each agency collects different data, with the most comprehensive information on CTPI benefits paid provided by the Transport Accident Commission (Vic) and the Motor Accident Commission (SA).

For Vic and SA, CTPI benefit expenditure are mapped with the following areas of expenditure:

- Public hospitals (row 01)
- Private hospitals (row 04)
- Patient transport services (row 12)
- Referred medical services (row 14)
- Dental services (row 15)
- Other health practitioners (row 16)
- Community health (row 20)
- All other medications (row 22)
- Aids and Appliances (row 24)
- Unreferred medical services (row 40).

The proportion of benefits paid in each area of health spending in Vic are used to allocate expenditure for each health area in NSW, Qld, WA and Tas. Population proportions are used to estimate CTPI provider health spending for ACT.

For some jurisdictions, revenues from CTPI providers reported in GHE NMDS 'Revenue' are also included in CTPI expenditure (in rows 01, 06, 12, 15, 20, 27, 30, 32).

Offsets

There are no offsets for column K.

Notes

The amounts funded by CTPI for Private hospitals (row 04), All other medications (row 22) and Aids and Appliances (row 24) are offset against Individuals (column H) in the respective area of expenditure.

The amounts for Public hospitals (row 01) funded by CTPI are offset against State and territory governments (column F) for some jurisdictions.

Column I – Other private

Expenditure components	Offsets	Notes
• Private hospitals non-patient revenue (row 04): data estimated from PHDB and ABS PHEC • Private capital expenditure (row 36): data estimated from ABS Private GFCF • Expenditure funded by private non-profit organisations on health research (rows 31 and 32): data from ABS Research and Experimental Development statistics • Revenue received by state and territory health organisations from other private sources (in various rows from 01 to 32): data from GHE NMDS 'Revenue'	None	None

Expenditure components

Other private expenditure is part of non-government funding of health goods and services (see Other private).

The data used for estimating spending are sourced from:

- Non-patient revenue of private hospitals (row 04) estimated from ABS PHEC and PHDB
- Capital expenditure from ABS Private GFCF (row 36)
- Expenditure funded by private non-profit organisations on health research (rows 31 and 32): data from ABS Research and Experimental Development statistics
- Revenue that state and territory health organisations received from other private sources (in various rows from 01 to 32): data from GHE NMDS 'Revenue'.

Offsets

There are no offsets for column I.

Notes

There are no further notes for column I.

Table T2: Data sources used to derive the Australian National Health Account

Data source	Notes
ABS Australian National Accounts: National Income, Expenditure and Product ABS Government Gross Fixed Capital Formation for Health (Government GFCF) ABS Private Gross Fixed Capital Formation for Healthcare and social assistance (Private GFCF)	These data provide information about capital expenditure (as outlined in Australian System of National Accounts (5204.0)) by: Government GFCF – general government fixed capital formation by level of government and purpose (health); table 53 Private GFCF – private gross fixed capital formation by industry (healthcare and social assistance); table 52
ABS Government Finance Statistics, Australia ABS Capital Consumption (depreciation) (Economic type framework 1231)	Prior to 2015, the Economic type framework 1231: depreciation of fixed assets (non-defence), which refers to amounts charged to current operations in respect of the consumption of non-current tangible assets not related to defence weapons platforms was based on the Government Finance Statistics framework outlined in 2005 (ABS Australian system of Government Finance Statistics; 5514.0). As of 2015, this category was revised to Economic type framework 1241. However, the ABS Government Finance Statistics publications and associated output continued to be published on the previous Government Finance Statistics framework as outlined in Australian System of Government Finance Statistics: Concepts Sources & Methods, Australia 2005 until September quarter 2017.
ABS Australian National Accounts: National Income, Expenditure and Product ABS Household Final Consumption Expenditure (HFCE)	
ABS Research and Experimental Development statistics ABS Research and Experimental Development, Higher Education Organisations, Australia (8111.0) ABS Research and Experimental Development, Government and Private Non-profit Organisations, Australia (8109.0)	Data on expenditure and human resources devoted to research and development (R&D) carried out by higher education organisations, government and private non-profit organisations in Australia. Data classification used is based on the socio-economic objective of the research as health. Data are collected biannually. Most recent surveys: Higher Education Organisations – 2018 Government and Private Non-profit Organisations – 2018–19
ABS PHEC (Private Health Establishments Collection)	The Private Health Establishments collection was an annual survey which collected information about the activities, staffing and finances of all private hospitals (private acute and psychiatric hospitals, and free-standing day hospital facilities). The results of the final survey were published in *Private Hospitals, Australia, 2016–17*. The ABS PHEC provided estimates of individual and other private spending on private hospitals. In 2017–18 these estimates were modelled from the final 2016-17 collection. However, as of 2018–19, individual spending was obtained from the Private Hospitals Data Bureau, while other private spending continued to be modelled on the final PHEC survey data.
Australian Department of Defence	Unpublished data request, provided by the Joint Health Command (since 2019-20)

APRA (Australian Prudential Regulation Authority) data Private Health Insurance Membership and Benefits Private Health Insurance Prostheses Report Operations of Private Health Insurers Annual Report	These data provide information about PHI, with most data provided on a quarterly basis at the state and territory level.
ATO (Australian Taxation Office) annual report	Data related to the PHI premium rebates claimed through tax. This information is published annually by the ATO.
Comcare	Data request, provided by Comcare
CTPI data The State Insurance Regulatory Authority (NSW) Transport Accident Commission (Vic) Motor Accident Insurance Commission in Queensland Insurance Commission of Western Australian Motor Accident Commission (SA) Motor Accidents Insurance Board (Tas) Territory Insurance Office (NT)	Data request, provided by jurisdictions' CTPI regulators
DoHAC (Department of Health and Aged Care) Program cost centres	Data provided by DoHAC annually
DVA (Department of Veterans' Affairs) MRCA and SRCA	Data request, provided by DVA
DVA (Department of Veterans' Affairs) NTA (National Treatment Account) program benefits	Data request, provided by DVA
GHE NMDS (Government Health Expenditure National Minimum Data Set) Revenue Gross expenditure Depreciation	The GHE NMDS collects information about the direct government and government-funded expenditure on health and health-related goods and services. The most recent NMDS was implemented from 2014. More information on the GHE NMDS can be found in AIHW METeOR.
MBS (Medical Benefits Schedule)	Data held at DoHAC, accessed by AIHW
NHMRC (National Health and Medical Research Council) grants	
NHFB (National Health Funding Body)	
PBS (Pharmaceutical Benefits Scheme) Section 85 Section 100	Data held at DoHAC, accessed by AIHW
PHDB (Private Hospitals Data Bureau)	Since 2018–19, these data were used to estimate of patient revenue in private hospitals. Prior to this ABS PHEC data provided this estimate.
RPBS (Repatriation Pharmaceutical Benefits Scheme)	

The Treasury Treasury Final Budget Outcome Tax Benchmarks and Variations Statement	Table 36 of the Treasury Final Budget Outcome provides the expenditure of the Australian Government on NHR funding and NPPs to the states and territories. This information is published annually. Net medical expenses tax rebate is included in the Tax Benchmarks and Variation Statement.
Workers' compensation data State Insurance Regulatory Authority (NSW) Worksafe Victoria Workcover Queensland Workcover WA ReturnToWork SA WorkSafe Tasmania WorkSafe ACT NT WorkSafe	

Note: Information regarding the data sources of deflators used for analysis presented in the HEA are not included in this table (see Box 2.6)

Australian Government
Australian Institute of Health and Welfare

Comparison and alignment of Australian health expenditure estimates

Comparison and alignment of Australian health expenditure estimates

In addition to the ANHA published by the AIHW, there are a range of other reports produced by other entities which include estimates of health expenditure. These include expenditure estimates:

- of government outlays on health, published by the Australian Bureau of Statistics (ABS) as part of Government Finance Statistics and Australia's National Accounts,
- related to hospitals published by the National Health Funding Body (NHFB) under National Health Reform Arrangements (and also published by the Australian Government Department of Health and Aged Care),
- published by state and territory governments in the annual reports of health agencies,
- of hospital costs published by the Independent Health and Aged Care Pricing Authority (IHACPA, previously named Independent Hospital Pricing Authority IHPA), and
- produced by the Organisation for Economic Cooperation and Development (OECD) and the World Health Organisation (WHO).

Over the past several years the AIHW has been working with the Australian Government Department of Health and Aged Care, state and territory governments, the ABS, the NHFB, and other data suppliers to work towards a better understanding of the various spending allocation methods and the consistency and alignment between them. This work has involved consultation through the national health expenditure data committees and, in 2019, the AIHW contracted Mr Peter Harper, a former Deputy Australian Statistician, to undertake a consultation and review of the various health expenditure reports.

One message that the AIHW has received from stakeholder consultation is that, although the majority of users of the health expenditure estimates understand that there are valid reasons for differences, a 'guide to health expenditure statistics' would be of value. In light of this feedback, the AIHW added a new section to the Health expenditure Australia 2018–19 report (published in 2020) to examine issues of consistency and alignment between different health expenditure estimates.

Notwithstanding that there are generally good reasons for differences in health expenditure statistics, there are benefits in working towards harmonisation if possible. This is an ongoing work program and the purpose of this report is to consolidate and expand on the work to date.

This chapter and Australian National Health Account: concepts, methodology and data source are complementary to Health expenditure Australia 2021–22 and future reports of the same series.

Comparison and alignment of Australian health expenditure estimates

On this page

The Australian National Health Accounts

The ANHA aims to support a long-term, whole-of-system understanding of health spending nationally and over time. This system is unique in Australia and it varies from other health system reporting in scope, degree of stability over time and classification systems used. Other systems tend to focus on specific funding programs, jurisdictions or time periods.

The long-term holistic approach requires developing methods to appropriately allocate spending figures from multiple, often overlapping and changing data sources. In doing so, care is taken to avoid the risk of misallocation, unnecessary breaks in the time series, missed data and double counting.

The methods used in the ANHA are overseen by the Health Expenditure Advisory Committee (HEAC). The HEAC includes subject matter experts and representatives from the Australian Government, all state and territory governments and the private sector. The AIHW has worked with the HEAC over many years to develop approaches to maximise the completeness and accuracy of the estimates over time and minimise the risk of double counting. For example, when estimating total spending on hospital services in a year, the funds the Australian Government gives to states and territories is subtracted from the hospital spending reported by the states and territories to derive the amount that the states and territories spent from their own resources.

This holistic approach, unique classification system and methods developed mean the figures reported here often vary from other data sources, particularly where other reporting tends to focus on specific funding programs, institutions, funders or purposes. For example, program-specific reporting such as for the Medicare Benefits Scheme, government budget papers or health department annual reports vary from the figures here due to differing classifications, scopes and methods used to account for double counting.

As part of ongoing data quality improvement activities, the AIHW, through the HEAC, works with the ABS, the Australian Government, state and territory governments, the NHFB, the OECD and other data suppliers to ensure the estimates presented in the ANHA are as complete and accurate as possible and reflect changes in health system financing over time.

Links:

Health expenditure Australia reports

Australian National Health Account: concepts, methodology and data sources

Australian Bureau of Statistics

The Australian Bureau of Statistics (ABS) publishes Government Finance Statistics (GFS) to provide statistics about the finances of the general government and non-financial corporations sector. The data is generally provided by Treasuries/Departments of Finance (Commonwealth and states and territories) and is taken from government finance systems. The basis for these systems is the general ledger transactions that are recorded in the various government agencies, including departments of health. GFS expenditure statistics are classified on the basis of the Classification of the Functions of Government (COFOG), which is an international statistical standard. One of the Divisions within COFOG is ‘Health’. This Division is broken down into six Groups, which are further broken down into a number of classes.

The ABS also publishes System of National Accounts (SNA) statistics which provide a comprehensive and systematic set of statistics on the structure of the economy. Within the National Accounts, estimates of government final consumption expenditure and household financial consumption expenditure on health are published. Estimates of government final consumption expenditure are further broken down into estimates of general government national final consumption expenditure and general government state final consumption expenditure. These estimates are based, respectively, on the COFOG and the Classification of Individual Consumption According to Purpose (COICOP).

Links:

GFS

SNA

Understanding the different approaches to reporting Australian health expenditure

Government health authorities

All governments within Australia produce a range of financial reports, including annual reports, budget papers and specific program data. The source data for these reports are audited financial statements and 'general ledgers'.

The AIHW works with the states and territories to improve the quality and consistency of health expenditure reporting. In addition, the AIHW has been working with jurisdictions to better understand the drivers of variability between the expenditure statistics reported in jurisdictional reports compared with the ANHA statistics. The result of the first phase of this work were published in the *Health expenditure Australia 2018–19* report (published in 2020) to examine issues of consistency and alignment between different health expenditure estimates, and presented in Table C2 in the report since HEA 2018–19.

Links:

Australian Department of Health and Aged Care annual reports

State and Territory Department of Health Annual reports:

- New South Wales Health

- Victoria Department of Health

- Queensland Health

- Western Australia Health

- South Australia Department for Health and Wellbeing

- Tasmania Department of Health

- Australian Capital Territory Health

- Northern Territory Health

National Health Reform Agreement funding

The Administrator of the National Health Funding Pool, supported by the National Health Funding Body (NHFB) publishes data on funding and payments through the National Health Funding Pool (NHFP) that was established under the National Health Reform Agreement (NHRA). These data form an important component of the spending outlined in this report, particularly with public hospital spending. However, not all public hospital spending outlined in this report is administered through the NHFP, so additional information sources are drawn on to capture the full scope of public hospital spending. From the perspective of the Australian Government, this includes spending such as by the Department of Veterans' Affairs (DVA), the PBS Section 100 programs, the DoHAC own programs, including blood and organ programs, all of which operate outside of the NHFP. From the perspective of the states and territories, their funding contributions through the NHFP do not match their figures provided through the GHE NMDS for a variety of reasons, including:

- additional 'top-up' funding provided to hospitals outside the NHFP where the cost of providing services exceeds the National Efficient Price under NHRA funding mechanisms and/or the particular services are outside the scope of NHRA arrangements,
- locally sourced revenue and associated spending may not be administered through the NHFP. Where hospitals have local revenue sources (for example, private patients, accommodation charges, sub-rent revenue and car parking fees) and this is used to fund hospital services, this funding may not be administered through the NHFP but is captured in the ANHA,
- funding related to centrally managed programs such as pathology and diagnostics services, where the provider for multiple hospitals might be contracted directly by the state/territory's health department (outside the NHFP), rather than these services being sourced by individual hospitals,
- non-hospital services funded through the NHFP. In some jurisdictions, services such as community care and public health may be funded by contributions administered through the NHFP. This spending is reported and treated separately under the ANHA, and
- differences between cash and accrual accounting cycles, which mean timing of cash payments, expenses and reporting can vary.

Links:

NHFB

Independent Health and Aged Care Pricing Authority

The Independent Health and Aged Care Pricing Authority (IHACPA, previously named Independent Hospital Pricing Authority IHPA) collects, validates and reports public hospital costing data under the National Hospital Cost Data Collection (NHCDC) to determine the National Efficient Price and National Efficient Cost for the purpose of Activity Based Funding (ABF) and Block Funding under the NHRA. These data have different scopes and standards compared with the ANHA. The IHACPA does not report public hospital spending in the aggregate level.

Links:

IHACPA

International reporting of health expenditure

Each year the AIHW provides a derivation of the ANHA to the Organisation for Economic Co-operation and Development and the World Health Organisation in accordance with the classification used for international reporting, known as the System of Health Accounts. Despite being derived from the same source data, differing classification systems can result in variations in expenditure for particular components of the health system.

Links:

OECD health expenditure

OECD A System of Health Accounts

WHO Global Health expenditure

Comparison and alignment of Australian health expenditure estimates

On this page

Outline

The differences in purpose, scope and coverage are the key reasons for the observed differences in health expenditure statistics across the different reports. In recent years the AIHW has worked with stakeholders in the HEAC to better understand the similarities and differences across the various health expenditure reporting entities. The first phase of this work was published in the *Health expenditure Australia 2018–19* report (published in 2020) with the inclusion of a report section which describes the various reports and the drivers of varying health expenditure estimates.

This section provides an analysis of the drivers of different health expenditure estimates across the various reporting entities.

Australian Bureau of Statistics

Variances in health expenditure statistics are due to the different scope and classifications systems used. For example, where spending through health insurance is considered part of the health system under the ANHA, it is considered part of the insurance sector in the System of National Accounts. Another reason for variation comes from the ABS use of the GFS as a source for government spending, which varies from the source used by the AIHW, which has been tailored specifically for the ANHA. While the basis for both systems is the general ledger transactions that are recorded by the various government agencies, including Departments of Health, the two vary for a number of reasons.

The relevant point of comparison between Government Finance Statistics (GFS) on health expenditure based on the Classification of the Functions of Government (COFOG) and those in the ANHA relates to statistics on Australian and jurisdictional government funding of expenditures. Reasons for differences include:

COFOG is a ‘purpose’ classification, which means that the basis for classifying expenditures is the purpose for which the expenditure relates, rather than the nature of the activity. This means, for example, that remote housing constructed for the purpose of housing doctors would be treated as health expenditure in COFOG.

The health division in COFOG potentially includes activities that are outside of the scope of the ANHA (for example, nursing and convalescent home services) and may exclude activities that are within the scope of the ANHA.

Within GFS, unconsolidated statistics of expenditures by state and territory governments include expenditures financed by transfers from the Australian Government. Consolidated statistics remove transactions between levels of government. This process is known as consolidation, and is performed to avoid double-counting of government transactions. Likewise, within GFS, statistics of expenditures by state governments includes expenditure financed by payments from non-government sources, which are excluded from health expenditures funded by state and territory governments in the ANHA.

Likewise, within GFS, statistics of expenditures by state governments includes expenditure financed by payments from non-government sources, which are excluded from health expenditures funded by state and territory governments in the ANHA.

The estimates of government final consumption expenditure in the System of National Accounts (SNA) can be compared with estimates of government funded health expenditure in the ANHA. Reasons for differences include:

Differences between GFS health expenditure statistics and ANHA expenditure statistics as described above, as the GFS statistics form the basis for the SNA estimates of government final consumption expenditure.

Health-related transfers from governments to households will not be included as government household final consumption expenditure. Instead, they will be reflected in estimates of private final consumption expenditure in the SNA. However, these transfers, because they are funded by government, are included as government funded expenditure in the ANHA.

Likewise, the estimates of household final consumption expenditure on health can be compared with estimates of non-government expenditures in the ANHA. Reasons for differences include:

Household final expenditure funded by government transfer to households, which will be shown as government funded expenditure in the ANHA.

Health expenditure by residents and non-residents on health care. Spending by non-residents in Australia is included in ANHA expenditure estimates, but is deducted from HFCE, while spending by Australian residents abroad are added to HFCE. These adjustments are recorded as net expenditure overseas (NEO).

The inclusion of any non-government expenditure in the ANHA that is treated as intermediate consumption expenditures in the SNA rather than HFCE (i.e. any health expenditures by businesses).

The treatment of health insurance providers administrative expenses. These are shown as part of non-government health expenditure in the ANHA. However, they are excluded from household final consumption expenditure in the SNA. In the SNA, these expenses are treated as input costs of the insurance industry, which produces insurance services. The household acquisition of health insurance services is recorded in the miscellaneous goods and services component of household final consumption expenses.

Furthermore, a range of different sources and methods are used to compile the various estimates of final consumption expenditure in the SNA and the ANHA estimates of non-government expenditure. The use of these different sources and methods will likely cause differences in the estimates in addition to the conceptual and scope differences mentioned above.

Government health authorities

While these jurisdictional reports generally use the same source data as are provided to the AIHW for the ANHA (audited financial statements and 'general ledgers'), variations in scope and methods can occur. Classifying the data to fit the ANHA classification system can require adjusting specific items to avoid duplication, or drawing on other data sources, such as hospital activity data, to 'fit' the spending into ANHA categories.

The ANHA data vary from the jurisdictional annual reports primarily because the ANHA is national in scope, not limited to a single department or jurisdiction, and must avoid double counting where there are transfers between agencies (and the same spending may be reported by both). An important contributor to this are the federal transfers and, in particular, National Health Reform Agreement payments as well as payments for programs such as for highly specialised drugs. The ANHA effectively 'removes' these amounts from state and territory spending and reports them under the Australian Government 'Health and other' category. Other reasons for variation include payments from insurers. To create an illustrative comparison with annual report figures here, a number of adjustments have been made to account for the main reasons for variation. In particular, where the transfers have been added back in to the state and territory figures, they have been removed from the Australian Government 'Health and other' category as they are not managed directly by DoHAC so do not appear in the annual report.

Some examples of drivers of variability between annual reports and the ANHA include:

- In some jurisdictions there are departments which encompass both health and human services functions which produce a single annual report across both areas.
- Staff engaged by a specific health service might technically be considered departmental staff in some states and territories. In these cases, spending can essentially be captured twice in the annual report but this duplication is eliminated for reporting to the AIHW.
- Health workforce programs are not considered in-scope for the ANHA but generally are considered health spending in the annual reports.
- Transfers between states and territories for the provision of health services may be duplicated in annual reports.

In preparing their submissions for the ANHA each year, the state and territories remove these scope and duplication issues from the data that is provided to the AIHW. To ensure this is done consistently over time and between jurisdictions, this work is overseen by the Health Expenditure Advisory Committee, which includes representatives from all jurisdictions and the AIHW is continuing to work with all jurisdictions to ensure transparency.

National Health Reform Agreement funding

The National Health Funding Body (NHFB) was established in 2011 to support funding and payments made under the *National Health Reform Act 2011 (COAG 2011)*. The NHFB estimates comprise two components – a state pool and a state managed fund. Payments into the state pool include:

- Australian Government payments for Activity Based Funding (ABF). These are payments based on activity levels in public hospitals. ABF funding is determined on the basis of the National Efficient Price, which is calculated by the Independent Health and Aged Care Pricing Authority (IHACPA, previously named Independent Hospital Pricing Authority IHPA).
- Australian Government block funding to support teaching and research undertaken in public hospitals, and for some public hospital services where it is more appropriate to be block funded, particularly for smaller rural and regional hospitals.
- State government ABF payments. These payments are calculated by the states as the system manager of the public hospital system. The service agreement between the state and each LHN specifies the service delivery and funding parameters.
- A public health component paid by the Commonwealth for disbursement to state governments for public health activities (such as vaccinations).

There are two relevant points of comparison between the statistics published by the NHFB and those in the ANHA:

- Comparison of total public hospital expenditure.
- Comparison of state funding for public hospitals.

On the Australian Government side, NHFB's published numbers on the Commonwealth contribution of the National Health Reform Agreement (NHRA) funding are directly used as the main component of Commonwealth public hospital funding in the ANHA. The ANHA estimates are calculated using information on total public hospital expenditure provided by jurisdictional departments of health. State and territory governments' own funding on public hospitals are derived by offsetting NHRA and other grants and revenues that states and territories received from the Australian Government and other sources.

The estimates of total public hospital funding from NHFB statistics and in the ANHA will differ because of:

- Consumption of fixed capital is included in the ANHA estimates, whereas it is not included in the NHFB statistics.
- Public hospital expenditure funded by other (ie non- NHRA) Australian Government grants, such as funding from the Department of Veterans' Affairs, Department of Health and Aged Care funded programs such as blood and organ programs, funding relating to PBS Section 100 programs, and funding relating to health insurance premium rebates are included in the ANHA estimates and not included the NHFB estimates.
- Public hospital expenditure funded by state and territory governments that is not covered by the NHRA are included in the ANHA estimates but not in the NHFB estimates. These include:
- The amounts paid into the pool reflect the jurisdiction's contribution based on the IHACPA's calculated national efficient price for the delivery of ABF services. As the actual cost of delivering these services can be greater than the national minimum price, jurisdictions provide top-up-funding to hospitals that does not go through the pool.
- In regard to the block funding pool, jurisdictions are free to determine the scope of the payments they make into the pool; and may also provide block funding to hospitals outside of the pool.
- Jurisdictions provide centrally-managed services to public hospitals, such as administrative and pathology services, that do not involve payments to hospitals. These services are part of expenditure on public hospital services but are not reflected in the NHFB estimates.
- Payments to LHNs by the NHFB that are used to fund non-public hospital services will be excluded in the ANHA public hospital expenditure estimates but included in the NHFB estimates. For example, in some jurisdictions it appears that block funding payments may include amounts related to community health services that are delivered through public hospitals.
- Interest payments are included in the NHFB estimates but not in the ANHA estimates.

Difference between cash and accrual accounting whereby NHRA-related expenditure may occur in one period but the cash funding may be provided in another.

Technical notes

Technical notes

ABF	Activity Based Funding
ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
ADF	Australian Defence Force
AIHW	Australian Institute of Health and Welfare
ANHA	Australia's National Health Accounts
ANHA	Australian National Health Account
APRA	Australian Prudential Regulation Authority
APS	Australian Public Services
ATO	Australian Taxation Office
COFOG	Classification of the Functions of Government
COICOP	Classification of Individual Consumption According to Purpose
CPAP	Chemotherapy Pharmaceutical Access Program
CTPI	Compulsory Third Party Insurance
DoHAC	Department of Health and Aged Care
DVA	Department of Veterans' Affairs
ETF	Economic type framework
GDP	gross domestic product
GFCE	government final consumption expenditure
GFCF	Gross Fixed Capital Formation
GFS	Government Finance Statistics
GHE NMDS	Government Health Expenditure National Minimum Data Set
GNE	gross national expenditure
GP	general practitioner
GST	goods and services tax
HEA	Health expenditure Australia
HEAC	Health Expenditure Advisory Committee
HED	AIHW Health Expenditure Database
HFCE	household final consumption expenditure
HSD	highly specialised drug
IHACPA	Independent Health and Aged Care Pricing Authority (IHACPA, previously named Independent Hospital Pricing Authority IHPA)
IPD	implicit price deflator
IRI	Information Resources Incorporated
LHN	Local health network

MBS	Medicare Benefits Schedule
MRCA	*Military Rehabilitation and Compensation Act 2004*
NHA	*National Health Act 1953*
NHFB	National Health Funding Body
NHFP	National Health Funding Pool
NHMRC	National Health and Medical Research Council
NHR	National Health Reform
NHRA	National Health Reform Agreement
NPA	National Partnership Agreement
NPCR	National Partnership on COVID-19 Response
NPP	National Partnership Payment
NSW	New South Wales
NT	Northern Territory
OECD	Organisation for Economic Co-operation and Development
PBS	Pharmaceutical Benefits Scheme
PHC	primary health care
PHDB	Private Hospital Data Bureau
PHEC	Private Health Establishments Collection
PHI	private health insurance
PPE	Personal protective equipment
Qld	Queensland
RPBS	Repatriation Pharmaceutical Benefits Scheme
SA	South Australia
SHA	System of Health Accounts
SRCA	*Safety Rehabilitation Compensation Act 1988*
Tas	Tasmania
Vic	Victoria
WA	Western Australia

Technical notes

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Technical notes

Activity Based Funding: Way of funding public hospitals so they get paid for the number and mix of patients they treat.

admitted patient: Patient who undergoes a hospital's formal admission process to receive treatment and/or care, and ends with a formal separation process.

average annual income: Calculated from average weekly earnings statistics, which are the average gross (before tax) earnings of employees. Estimates of average weekly earnings are derived by dividing estimates of weekly total earnings of the number of employees.

capital consumption: Amount of fixed capital used each year. Also referred to as depreciation.

chain price index: Annually re weighted index providing a close approximation to measures of pure price change.

co-payment: Payment made by an individual who shares the cost of goods and services with third party payers, such as a private health insurance provider or the Australian Government for a PBS or Repatriation PBS medicine (see out-of-pocket costs).

hospital services: Services provided to a patient receiving admitted patient services or non-admitted patient services in a hospital, but excluding non-admitted dental services, community health services, patient transport services, public health activities and health research done within the hospital. Can include services provided off site, such as dialysis or hospital in the home.

individual net worth: Calculated from household net worth, which is the difference between the stock of assets (financial and non-financial) and stock of liabilities (including shares and other equity).

local government: The 6 states and the Northern Territory have established a further level of government. Local governments handle community needs such as waste collection, public recreation facilities and town planning. In the Australian Capital Territory, responsibilities usually handled by local government are administered by the territory government.

Medicare: National, government-funded scheme that subsidises the cost of personal medical services for all Australians and aims to help them afford medical care. The MBS is the listing of the Medicare services subsidised by the Australian Government. The schedule is part of the wider Medicare Benefits Scheme (Medicare).

out-of-pocket costs: Total costs incurred by individuals for health-care services over and above any refunds from the MBS, the PBS and private health insurance funds (see co-payment).

over-the-counter medicines: Medicinal preparations that are not prescription medicines and are primarily bought from pharmacies and supermarkets.

Pharmaceutical Benefits Scheme (PBS): National, government-funded scheme that subsidises the cost of a wide variety of pharmaceutical drugs (see Repatriation Pharmaceutical Benefits Scheme).

private patient: Person admitted to a private hospital or to a public hospital who decides to choose the doctors who will treat them or to have private ward accommodation. These patients are charged for medical services, food and accommodation.

public patient: Person admitted to hospital at no charge and mostly funded through public sector health or hospital service budgets.

Repatriation Pharmaceutical Benefits Scheme (Repatriation PBS): Provides assistance to eligible veterans (with recognised war or service related disabilities) and their dependants for pharmaceuticals listed on the PBS and a supplementary repatriation list, at the same cost as patients entitled to the concessional payment under the PBS (see Pharmaceutical Benefits Scheme).

total health price index: Ratio of total national health expenditure at current prices, to total national health expenditure at constant prices.

Notes

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Data

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